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Comparing Women Registered Nurses Perceptions and Experiences of Personal and Professional Development (PPD) in South Africa and the United Kingdom.

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Author declaration: This thesis has been composed by myself, the work has not been submitted for any other degree or professional qualification. Any included publications are my own work,

Signed:

Lindy Hatfield

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Abstract of Thesis

Background: Personal and Professional Development (PPD) is a global requirement for Registered Nurses (RNs) to be able to continue to practice following initial qualification. Women RNs face challenges in career progression and may experience issues particular to women and women's roles in undertaking PPD. Literature suggests that there are many different elements and factors associated with and influencing PPD both directly and indirectly and that women face gender related issues and challenges undertaking PPD. An understanding of women RNs perceptions and experiences of PPD from two different countries would enable both similarities and differences in experiences to be explored.

Aim: To compare women Registered Nurses' perceptions and experiences of PPD in South Africa (SA) the United Kingdom (UK).

Design: A constructivist grounded theory approach was taken. Knowledge is generated from the data, participants and the researcher are both involved in constructing the knowledge. The researcher undertaking a reflexive approach (Charmaz, 2006).

Sample: The sample comprised 39 RN's at different stages of their nursing careers and their ages ranged from 25-62 years old. RNs from two universities in the UK (one in the North West of England and one in Scotland) and from two universities from the Western Cape Province in South Africa took part.

Data collection: Data was collected between September 2013 and April 2014. Ethical approval was obtained from universities at which participants were currently studying or had recently completed studies. Data collection involved interviews and demographic details forms. Qualitative data analysis was undertaken using constant comparative method.

Findings: This study attempted to unravel the complexity of women RNs' perceptions and experiences of PPD. It revealed the constraints and barriers placed on women RNs, inside and outside of the work environment that impacted on their PPD journeys. Revealing patterns of women's PPD in relation to their experiences, perceptions, approach, strategies and aspirations and what women themselves perceived as the benefits and rewards of PPD. One core and three main themes evolved from the categories derived from the Constructivist Grounded Theory (CGT). The core theme was 'Women's perceptions, experiences, and the rewards of personal and professional development'. The three main themes were: engagement, aspirations and circumstances that can influence and/or limit PPD; the hidden costs of PPD; Women's PPD journeys. Similarities and differences between each country were identified and highlighted in the presentation of the findings. Implications of these findings resulted in recommendations made for future policy, education, practice and research.

The results included the emerging PPD Model that can be used to interpret the way in which we think globally about PPD for women RNs. Such knowledge of the constraints and barriers and to how women tackled them may pave the way to reduce and create better ways of working to enable all RN's to have opportunities to undertake PPD activities and to achieve their full potential.

Lay Summary of Thesis

Background: This is a study comparing how women who work as qualified nurses in the United Kingdom (UK) and South Africa (SA) experience ongoing education to continue their development as professional nurses. As healthcare services develop, it is becoming a requirement across the world for women who are qualified nurses to keep up to date and develop their knowledge and skills. What has been written in professional journals and books suggests that there are many different factors that influence nurses' experiences of this type of education and development. In particular, women face gender related issues and challenges when undertaking professional and personal development (PPD).

Aims: To compare women Registered Nurses' (RN) perceptions and experiences of PPD in the UK and SA. To identify the ways in which women as RN's have approached their PPD.

The study was designed to understand and explain how women registered nurses experienced and perceived PPD that collected information mostly through interviews. A form was also used to collect background information on the nurses. The research was in several phases so that information gathered at the start of the study was analysed and could lead to more targeted information gathering in the later parts of the study.

Findings: This study attempted to unravel the complexity of women RNs' perceptions and experiences of personal and professional development (PPD). The study revealed there were constraints and barriers experienced by women registered nurses both inside and outside of the workplace which impacted on them taking part in personal and professional development. Revealing patterns of women's PPD in relation to their experiences, perceptions, approach, strategies and aspirations. And to what women perceived themselves, as the benefits and rewards of PPD.

Implications of these findings resulted in recommendations made for future practice, education, research and policy. To remain as registered professionals RNs need to have access to PPD. Knowledge from this study, included the emerging PPD Model that can be used to interpret the way in which we think globally about PPD for women RNs. Such knowledge may pave the way to reducing constraints and barriers and create better ways of working to enable all RN's to have opportunities to undertake PPD activities and to achieve their full potential.

Glossary and abbreviated acronyms

Copies of this Thesis will be donated to SA universities and stored in a UK university library. Readers of this Thesis may be unfamiliar of the differences in SA and the UK. For the benefit of the readers the appendices offer further insight into the comparisons between each country. This glossary has been written to provide clear information to readers from overseas, UK and SA. For these purposes there are three sections: International, UK and SA. In this Thesis Women Registered Nurses has been abbreviated to WRNs.

International Glossary

International Council of Nursing (ICN)

World Health Organisation (WHO)

UK Glossary

ANP: Advanced Nurse Practitioner is a title used for RNs and healthcare professionals. They can hold a range of academic qualifications, and ANP qualifications are now set at masters' level.

Appraisal: This is a yearly meeting between the line manager and the employee. A review of the employee's performance is undertaken and documented.

Band: The pay scale system used by the NHS for registered nurses banding scales starts at 5 rising to the highest level of 9.

Career Framework: Offers description and guidance by providing a structure that may detail nationally agreed: employment grades/scales given for the job role/speciality (e.g. advanced practitioner). Alongside this it may list the minimal requirements for example, qualifications (that are aligned to the country's national qualifications framework) and the number of years

experienced required. Career frameworks aim to aid career planning and job satisfaction. Encouraging the development of knowledge and skills that can lead to taking on new roles and responsibilities which can aid career development and PPD.

CPD: Continuing Professional Development

CPR: Cardiopulmonary resuscitation, this training is one of the core trainings that are often classed as a mandatory yearly trainings for registered nurses.

Down-grading or Down-banding: a phrase used in the UK to describe RNs who have experienced their pay scale being changed to a lower grade due to service revision of staffing roles.

Education Co-ordinator: A person who manages and controls, with some reason, the budget for the education and training of staff, and delivers training.

Education and Development Departments: These are situated in most UK NHS hospital Trusts whereas in the SA NHS not all hospitals have them.

ENB: English National Board (nursing regulatory body disbanded and replaced by the NMC).

EN: Enrolled Nurse. ENs are 2nd level nurses who are registered to practice by the nursing regulatory body. SA and UK no longer offer EN training.

Extended Roles: Arrangements are made by the employer to train, educate and assess nurses to carry out additional roles, in which they are insured by their employer to undertake. For some extended roles this results in a higher grade or a move to the next increment in the grade/band.

Formal qualifications: a qualification recognised by the professional bodies and/or regulatory bodies (such as training, counselling, tutoring, mentorship, apprenticeship or higher education).

Formal PPD: Courses, academic qualifications, specialist courses with academic accreditation.

Funding stream: Monies set aside to fund and provide resources for a named project.

Grades: Describing the grade that the RN pay scale is situated. The UK's old NHS pay scale used the term grade, this is now called banding. Registered nurse grades would go from D to G grade. The job descriptions and responsibilities are not comparable with the current banded job pay scales.

HR: Human Resources

HCPC: Health Care Professions Council is the UK regulatory body responsible for setting and maintaining standards.

ICN: International Council of Nurses is a federation of national nurses' associations representing nurses worldwide.

Informal training: for the purpose of this dissertation this incorporates the following: in-house training, on the job training, work experience, shadowing, coaching, clinical supervision, job exchanges, work based learning, RCN 2012

In-house training: Core training that employers have identified as necessary, they deliver these within the workplace (some training can be termed as mandatory).

KSF: Knowledge and Skills Framework promoted by the NHS. The KSF 6 core knowledge and skills were aimed to make strong links to the appraisal system.

Learning can take place via the following: self-directed learning, experiential learning, reflective practice, distance and e-learning, work based learning.

Mandatory Training: Core training that the employer decided needs to be carried out by employees. Some mandatory training is only for certain staff roles. In the UK the employer requires staff to carry out mandatory training activities on a yearly basis. The employer is required to hold records of staff activity.

Mentorship: the name for the current mentorship qualification; learning and assessment. This is a qualification stipulated and recognised by the NMC and at the present time of writing can often be placed as essential requirement for nursing jobs banded at band 6 in the UK. SA has no equivalent qualification, or stipulation for RN's supporting and assessing learners, to have any qualification other than RN.

NMC: Nursing and Midwifery Council this is the nursing regulatory body of which all RNs must be registered to practice.

NMC Pin Number: Personal number of a nurse registrant on the NMC register.

Nurse Practitioner: This is the same as the ANP.

QCF: Qualifications and Credit Framework, this replaced the National Qualifications Framework, (QAA 2001). They explain the academic grading for post-registration nursing qualifications at diploma, degree and masters.

On-line: Resources that can be found via the worldwide web, and web pages and computer packages designed for RNs to access that are connected to the employer's intranet.

PADR: Performance Appraisal and Development Reviews

Performance Review: Part of the appraisal process in which a review takes place of the evidence provided for the appraisal.

PDP: Personal Development Plan (NHS). This term was first used in the NHS (2011) Working together, learning together document. Jasper and Mooney (2014) argue that this is a professional development plan, and not a personal development plan.

PDP: Personal Development Planning: PDP is described as *'a structured and supported process undertaken by an individual to reflect upon their own learning, performance and /or achievement and to plan for their personal, educational and career development'* (QAA, 2011).

PDR: Personal Development Review

PPD: Personal and Professional Development

PPD activities: A term defined by the researcher where personal and professional development activities are split into formal and informal.

PREP: Post Registration Education and Practice

Protected learning: This means that the course that that person is studying cannot be cancelled or that the line manager can expect the person to work that day instead of undertaking the agreed study.

United Kingdom (UK): This country incorporates the four countries; England, Scotland, Wales, and Northern Ireland.

UKCC: Central Council for Nursing (Regulatory body disbanded and replaced by the NMC).

United Kingdom languages: English, Welsh and Scottish Gaelic

RCN: Royal College of Nursing the UK's largest professional association and union with 425,000 members in 2015.

Revalidation: NMC re-registration process. UK RN's are required to submit evidence to the NMC every 3 years, which demonstrates that they carry out

reflective practice in relation to their code of conduct and scope of practice. Once approved they can continue to be registered with the NMC.

RN: Registered Nurse 1st level nurse who is registered with the nursing regulatory body.

Scope of Professional Practice: *'The professionals' area of practice in which they have knowledge, skills and experience to work safely and effectively, in a way that meets standards and does not present any risk to the public or to the health care professional'* (Health Care Professions Council (HCPC) 2006).

Short staffing: termed where it is viewed by the nurse that there is not enough nurses and other staff to provide a standard of nursing care. This may or may not include reference to the nurse patient ratio. Or that there are not enough staff for the nurse to conduct PPD activities or be released to attend PPD activities.

Service manager: this is a manager that manages a service that covers a speciality or number of specialities.

Time owing: Another term to describe time off in lieu that many employers use.

South African Glossary

Auxiliary nurse: auxiliary nurse may hold the higher certificate in auxiliary nursing and be registered by the SANC.

Black Economic Empowerment Commission Report (BEE) (2001).

Bridging Course: A course for nursing assistants to study a course that will lead them to becoming an enrolled nurse. And a course that can lead to enrolled nurses becoming a professional nurse

Chief Nursing Officer: SA's first CNO was appointed in 2014 under the directions of the WHO.

DENOSA: Democratic Nursing Organisation of South Africa. This has a dual role of being a trade union and a professional association. Biggest nursing union in SA.84,000 members in 2015.

Community Year Service: A newly qualified nurse has to complete this 1 year of community service before gaining full registration with SANC. In the Western Cape, SA student nurses must sign a contract on commencement of their 4-year nurse training programme, this includes that on qualification newly qualified nurses must stay and work in the Western Cape, SA. To carry out 12 months of work in community service. On completed of the Community Service Year the nurse needs to register with the nursing council as Professional Nurse with effect from the end of the month in which community service was completed.

CPD Points: The SA government requires records from self-employed nurses to demonstrate that they have attended the required in-service training days, record these as CPD points. On presentation of these records the nurse is granted permission from the government to work as a self-employed nurse.

Direct Supervisor: Another term for a Line Manager

Eastern Cape Province: This is one SA's poorest provinces.

Enrolled Nurse Assistants: An old term that will no longer be used in future as SANC will be changing this named qualification in the future.

Extended Roles: Arrangements are made by the employer to train, educate and assess nurses to carryout additional roles, in which they are insured by the employer to carry out.

HPPD: Hours Per Patient Day, this is similar to the WHO's Nurse: Patient Ratio.

In-service Training: The SA term in-service training is not equivalent to UK term mandatory training. In-service also includes teaching sessions run by staff in the team/workplace. They often involve groups from all professions meeting to learn and discuss the topic of discussion.

Matric: A series of exams in SA that is regarded as the last stage of exams for standard school education, matriculation at Grade/year 12 is the standard required for application into for nurse training/university education. (Several women in this study as mature students returned to study for their matric so that they could undertake nurse training, some of these women stated that in the school that they attended (often rural areas), there was no offer the opportunity to sit matric exams). Over the past 10 years the governmental incentives have demonstrated that they have improved girls educational achievements in schools.

Moonlighting: An additional paid work whilst holding a primary job role (in SA attempts have been made by employers to state that staff cannot do this by placing this stipulation into the employment contract).

NDH: National Department of Health

NEHAWU: National Educational, Health and Allied Health Workers Union (a SA public sector union).

Netcare: A Private healthcare organisation

Nurses Pledge: a pledge that nurses take themselves between them and their patients, and it is said at graduation ceremonies. Nurses make this pledge when qualifying at graduation. Some professional nurses repeat this pledge at meetings and conferences. They do not have a code of conduct like the UK however they do have a code of ethics.

Nursing Service Managers: This a similar role to a UK Matron or Sister.

Nursing Assistants: A nursing assistant holds a qualification recorded by the regulatory nursing body. (They can undertake training called a bridging course to gain the enrolled nurse qualification).

Operational Managers: the new term from the old term "Matron".

OSD: Occupational Specific Dispensation Remuneration Policy.

PHSDSBC: Public Health and Social Development Bargaining Council.
Pledge of Service: Nurses Pledge of Service is used by SANC.

RESON: Research on the State of Nursing Projects their research aims to develop and strength the research evidence.

RSA: Republic of South Africa (official name for SA).

SA: South Africa.

Salary Notches: Salary pay scale levels.

Shift Leader: Person managing the shift.

Staff Performance Management System (SPMS): Registered nurses are required to review their performance every quarter of the year.

SANC: South African Nurses Council.

SANNAM: South African Network of Nurses and Midwives.

Skills Development Fund: a funding scheme that some RNs had been able to access to support their academic studies.

South Africa: This country incorporates the 9 Provinces: Eastern Cape, Free State, Gauteng, KwaZulu-Natal, Limpopo, Mpumalanga, North West and Western Cape.

Specialist Nurse: A grading given to SA RN by the OSD pay scale. N.B. These were nurses who had been employed on the nurse specialist grade when the OSD was first implemented and were nearing the end of the time period to complete the qualification as set by the original OSD agreement and job criteria.

Staff Nurse: Enrolled nurse

Western Cape Provence: This area is governed differently than Eastern Cape.

UNISA: University of South Africa this is equivalent to the UK's Open University.

UHC: Universal Healthcare Coverage this is aims to improve population health and achieve equity and social justice for all of SA's.

UK expressions and figures of speech:

"Stiff upper lip": when they don't talk about their difficulties or experiences and just get on with it.

"Don't air your dirty washing": when they don't talk about things that are not advisable or suggest something improper happened.

SA expressions and figures of speech:

Ja = "Yes" in English

"Pull your hair out or pull your teeth out": An expression used to describe to when others try to stop you from doing something such as wishing to develop yourself and seek higher status roles.

"Tall poppy syndrome": An expression used to describe to when someone becomes too tall, they will get their head chopped of like a poppy. This

expression warns that you can be successful and earn better money than others, but warns you not to leave the community that you live in, otherwise you could face consequences for no longer being part of the community. In this study unsupportive behaviours and professional jealously are examples of this. Whereby members of a group can be treated differently because of the PPD that they are undertaking.

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Chapter 1: **Introduction**

The study's overall research aim was to question what are to women Registered Nurses' (WRNs) perceptions and experiences of Personal and Professional Development (PPD) and it's aim was to undertake a comparison between the United Kingdom (UK) and South Africa (SA) RNs. This introductory section outlines the rationale, and the importance of PPD in nursing today and the concerns that are being raised in that RNs are struggling to engage in PPD activities that are both informal and formal that are essential to RNs development within their roles. The reader is introduced to the theory and practice of PPD, and how nursing in SA and the UK compare to one another is outlined. A combined glossary has been provided to offer guidance on the abbreviations, terms and meanings used in this study since each country has common terms and abbreviations which may not be familiar to those in other countries. Appendix A provides more detailed background information to support the comparisons made between SA and the UK.

Findings from the initial literature search and review that was conducted at the beginning of the study in 2011, though sources suggested key components of development they revealed a conflict over the understanding as to what PPD is. What is known is though there were definitions to what CPD (Continuing Professional Development) and Life Long Learning (LLL) both of which play a part in PPD, there was no offer of a clear definition of PPD, and little research was found on nurses' perceptions and experiences of PPD. A working definition of PPD was that this incorporated both personal and professional development. Additionally, this initial search raised questions as to whether there is a dividing line between the personal and professional development of an individual WRN and how this interacts with their professional and personal lives.

Despite the positive literature that supports the concept of PPD and the policies, strategies and frameworks that claim to support and aid nurses' PPD, it was found that nurses' had many negative perceptions and experiences (Hughes, 2005; Gould, Drey and Berridge 2007). That nurses views on what support they want and need can be very different to what they experience, which raises questions about support, and how this may have an effect WRNs PPD (Gould *et al.* 2007; Munroe, 2008).

When exploring the literature on WRN's perceptions and experiences of PPD, there was some literature that explored some of the difficulties women faced, but it was limited and appeared to lack depth. It brought me to recognise the absence of individual women's voices within the nursing literature. Much of the literature had referred to both men and WRNs, with only a few comments relating to women, which may have been due to the methods used to collect data, and the way that the analysis took place. It was of paramount importance to find out what WRNs defined, understood and experienced PPD to be. As the nursing profession is heavily dominated by women (NMC, 2015; SANC, 2016b) who may experience particular gender based issues in relation to PPD, it was deemed that women needed to be central to this research (Ramazanoglu and Holland, 2002).

Nursing worldwide has raised deep concerns with regards to RNs poor working conditions and the socio-economic factors WRNs experience and as a result in the International Council for Nurse's (ICN) calls for positive practice environments (All-Party Parliamentary Group on Global Health (APPG), 2016; ICN), 2007, 2010b, 2015a; Democratic Nursing Institution of South Africa (DENOSA), 2016a).

The commonalities between both the SA and the UK NHS is that they both face challenges of a growing and ageing population, care of patients with long term and/or chronic conditions, and an increase in patients/clients expectations, in addition to the developing technological and scientific

advances that require continuous updating of the IT infrastructure and modern equipment (Royal College of Nurses (RCN), 2018). As a result, services face increasing costs to deliver healthcare, and attempts to continuously change as it meets these organisational challenges. Those countries that have a NHS like the UK and SA, that offer treatment on demand (the UK having universal health coverage for their citizens and SA currently adopting a broader system into their NHS), are struggling to accommodate the growing service needs and demands of their nation's healthcare (Appendix A).

SA and the UK have similar structures for their healthcare systems, having both public and private healthcare organisations. Training, qualifications, and regulation and registration of nurses is managed by a nursing regulatory body in both countries. However, the history of nursing differs in that SA operated apartheid that divided people by treating them differently according to class, race and gender. Today SA still struggles with these issues and those of power and hierarchy. The Black Economic Empowerment (BEE) policy which was established in an attempt to counteract prior disadvantages is argued to advantage some SA people, yet disadvantage others (BEE, 2014). Poverty and standards of living differ between the two countries, SA having a significant rich poor divide with 56% of its population living in poverty (statss.gov.za, 2016c) in comparison to the UK where less than 15-20% live in poverty (Full Fact, 2016). Race, class, ethnicity, religion and language differ between the two countries and this in turn can impact on women's lives.

Nursing is heavily dominated by women (NMC, 2015; SANC, 2016b, and Appendix A details facts and figures in relation to the population of each country and nurses), who may find professional status, education, opportunity of career and promotion, financial security, pensions, sick pay and other benefits far more attractive than other types of work that do not offer these (Beninart, 2001, Department of Women, 2015). For many women,

they continue to hold responsibilities within the home such as housework and caring roles, as well as working an as an RN (Hoschchild, 2012), this in turn has an impact on their approach toward their PPD (see Appendix A and the Glossary that demonstrates the terms and contributes to understanding the differences of each country).

As nursing becomes a self-regulated profession, many nursing regulatory bodies now stipulate PPD is essential and RNs must show evidence of PPD in order to re-register (for example Nursing Council of New Zealand, 2012a; Nursing and Midwifery Council (NMC), 2015a; South African Nursing Council (SANC), 2018b). To be able to practise safely according to requirements of their regulatory body, employers insist RNs must update themselves through PPD to keep abreast of changes and undertake future roles in healthcare (APPG, 2016; ICN, 2001a, 2010a, 2015, 2017; SANC, 2013, 2018b; NMC,2015b, 2018). For women to develop and progress within their nursing careers, they need to meet the criteria set within job specifications. Hence, they need to have evidence of engaging in PPD to apply for jobs that stipulate courses, academic accreditation and experience. NHS employers have created frameworks which identify PPD as linked to job roles and pay scales (South African Government Information, 2007b; nhsemployers.org, 2016).

RNs maintain their competence through continual learning, and hence need to be able to engage in PPD, (ICN, 2001b, 2012; Donner and Wheeler, 2010). Employers have CPD budgets allocated for employee development , however, cuts that have been made in healthcare budgets have resulted in managers having to reduce expenditure (RCN, 2013b, 2014; 2015b). It could be suggested that as cuts in CPD budgets are not viewed as services reduction to the patient, they face a higher risk of being cut than other budgets. What was once a normal occurrence of an employer providing time and funding for CPD for RNs to engage in development activities, has now become a rare occurrence in many healthcare environments (RCN, 2014).

RNs can no longer expect their employers to fund courses or release them from the workplace within paid worktime. Nor can they expect to be able to be engaged in development activities that require resources from their employers such as time, staffing and other costs. Thus, the actions of reducing CPD budgets threatens RNs opportunities to develop themselves and even to maintain their practice.

The comparison between SA and the UK will provide an opportunity to gain knowledge and understanding of PPD within different settings, so highlighting the commonalities that women share as well as the differences. SA has had a troubled deeply racist history and lives blighted by apartheid. SA and UK both have an NHS, and nursing regulatory bodies that set standards for education, training and registration of nurses and they each hold a nursing register. However, they differ in size, culture and economic status, all of which impact on women's lives and nursing's status.

For WRNs to become successful in PPD, a much deeper and critical understanding of this subject is needed. WRNs need ownership of PPD in order to be clear what their concept of PPD is, of what drives them to engage in PPD activities and to be able to negotiate with stakeholders. Without this, the gap between what WRNs view as support for PPD and what is not supportive, can cause much resentment between themselves and their employers (Beatty, 2001; Hughes, 2005). This study aims to add new knowledge and understanding of these issues in order to influence the way in which RN and their stakeholders view and approach PPD, making it a far more successful activity for all RNs and in turn, for their employers.

The design of this study is based in Constructivist Grounded Theory (CGT), which requires constant comparison of data, and reflexivity. In addition, a decision was taken to use a feminist approach in order to listen to an array of women's voices and give prominence to gender-based issues for WRNs. The differences between the two countries are also acknowledged, with

differences between women's' experiences being highlighted and explored in the analysis. Ramazanoglu and Holland (2002) argue that such comparative analysis can connect ideas, experience and reality and so generate a social process of knowledge production. Holloway and Galvin (2017, p194) suggest that in CGT *'reality emerges or is discovered in the context of interaction'*. Hence, a process of CGT was followed ranging across and between the two countries. A comprehensive results section has therefore been provided to represent the participants' voices.

The findings from this research are used with a feminist approach to offer a unique contribution towards the knowledge of WRNs experiences and perceptions of PPD in SA and the UK. For one of the aims of CGT is to generate new theory (Charmaz, 2014). An emerging PPD Model was created from the findings of this study acting as a basis for further theoretical development. Along with examples of women's perceptions and experiences, it adds to the theory that will be used to inform others such as line mangers and individuals themselves about women's perceptions and experiences of PPD. This knowledge can provide a greater understanding of what WRNs experience and perceive with regards to engagement in PPD activities and explores any dissonance between women's own perceptions and what they perceive as the employers' perceptions of PPD.

Through exploring some of the difficulties (expected and unexpected) and negative perceptions that women experience in PPD, the research has revealed effective strategies and techniques some of these women have used to overcome these challenges. Exploration of women's positive perceptions and experiences of PPD demonstrated the rewards and values women placed on PPD activities, and in addition women's experiences as to how and why they had benefitted from PPD activities.

By using a feminist approach, the research has highlighted the gender-based issues that WRNs experienced and perceived in PPD and the ways in which

these women approached, acted and managed their engagement in PPD activities. Women's experiences and perceptions of PPD differ from one another, and the level of engagement changes according to their personal circumstances, aspirations, perceptions and experience of PPD activities.

The sharing of the research findings may lead to RNs, as individuals, becoming more engaged in PPD activities. They may become more aware of how to plan, make decisions and take action on the PPD activities that they wish to engage in. Knowledge of women's PPD journeys and what level of engagement of PPD they can engage in, within that time of their lives, could lead to a better understanding of women's engagement in PPD. RNs employed in leadership and managerial roles could influence practice and policy with regards to managing, motivating and supporting WRNs engagement in PPD activities which the APPG recommend as essential for RNs development (APPG, 2016). The PPD Model developed in this study may help raise awareness and increase insight into women lives and the difficulties they may face when attempting to access and engage in PPD. In turn, line managers could support RNs by helping them to navigate through the barriers which may prevent participation, offering them advice and guidance based on the findings of this study (APPG, 2016).

Knowledge gained from this research could benefit and empower WRNs in their future PPD whilst also enlightening and shaping future employer support for PPD. In addition, this research was designed to provide an insight on the ways in which women had successfully approached, utilised and managed their PPD activities, which led to them becoming empowered, achieving their potential in academic study, engaging in other PPD activities, fulfilling aspirations and gaining envisaged rewards. As RNs decide to leave the nursing profession because of poor working conditions and the lack of rewards or promotion (The Kings Fund, 2015; World Health Organisation (WHO), 2016) it is important this knowledge is used to help WRNs to navigate PPD in the ever changing environment of healthcare.

The findings of this study will enhance our understanding and the development of theory in relation to the perceptions and experiences of PPD and what effect they may have in the future for RNs and employers in relation to PPD. Without this knowledge, as Jasper and Mooney (2013) argue, it will be difficult to identify what RNs perceptions are of PPD.

In Chapter 2: the literature review followed the CGT approach acknowledging that literature reviewed prior to the collect of data and analysis acts to contribute to the researcher's further analysis of data (Ramahlo *et al.*, 2015). It outlines the issues within nursing literature that surrounds PPD for WRNs. Chapter 3: presents and discusses the methodology used, constant comparison and reflexivity supported the use of the CGT approach within this study (Ramahlo *et al*, 2015). This approach was chosen as it recognises that the researcher cannot be divorced from the research and CGT would promote the focus on both the micro and the macro aspects of which are situated with the lived experience of WRN's (Charmaz, 2008). The feminist approach was used to identify issues that feminists argue are central to women such as differing uses of power and oppression used against women (Scholz, 2010). Chapter 4: has the findings from the core Theme 1 which answers the research question as to what were RNs perceptions and experiences of PPD, including those perceptions and experiences of PPD activities and women's perceptions of the differing levels of engagement, women's perceptions to what employer PPD means, the benefits and rewards of PPD and a definition of PPD. Chapter 5: presents the main themes that branched from the core theme. The main themes were; 2nd theme – Women's perceptions and experiences of engagement, aspirations and circumstances that can influence and/or limit PPD , 3rd theme – The Hidden Costs of PPD activities and women used to overcome the difficulties, 4th theme – Women's PPD journeys, all of which support the core theme and the new knowledge derived from these findings that have led to the construction of the emerging PPD Model (Figure 6) discussed in Chapter 6:.

Chapter 6: discusses the findings whilst Chapter 7: concludes the study, acknowledges its limitations and offers recommendations to transform women's lives by developing women centred PPD grounded in the reality of their everyday lives.

Chapter 2: **Literature Review**

The overall aim of this study was to compare women Registered Nurses' (WRNs) perceptions and experiences of personal and professional development in SA and the UK.

Bryman (2016) states that the purpose of a literature review is to establish what is known about the topic, and to justify the reasons, background and purpose of the research study. For this study, a constructivist grounded theory (CGT) approach was used and so the literature searches commenced in January 2011 and continued in 2012, 2013, 2016, 2018, and up until the completion of the thesis in 2020 (Appendix B), (Keane, 2015, Ramalhlo *et al.* 2015).

Savin-Baden and Howell Major (2013) state that there are differing opinions on how and when to undertake a literature review in CGT. Charmaz (2016) argues that the argument that no literature can be reviewed prior to the study so not to "infect" the results is outdated and unrealistic. Keane (2015) asserts that the researcher needs to explicitly acknowledge previous and ongoing professional engagement with the literature. Flick (2018a, p13) suggests that we should *'take the existing substantive literature into account but try to reflect where it begins to impose on your perception of the phenomena in the field in a restricting way'*. Thus, reflexivity was used within the analysis of the literature within this study. Bell (2010) suggests to carry out a 'first thoughts list' at the start of a study to help establish the focus, which along with re-reading on the topic of PPD, supports Keane's (2015) argument of being open and honest about what you do know. A topic guide was created, and this helped confirm the key words to be used in the search for literature at the beginning of the study (Moule, Aveyard and Goodman, 2017) (see Appendix C.

In this study an initial literature review took place using a systematic approach to question what the experiences and perceptions RNs had on

PPD (Aveyard 2010, 2014) and, subsequently, searches for literature were undertaken whilst the research was being conducted to ensure that I understood the historical and cultural aspects that affected SA and UK WRNs which emerged during concurrent data collection and analysis (Charmaz, 2016). Other articles or sources found that related to the study were reserved for reading after the CGT analysis had finally concluded (Savin-Baden and Howell Major, 2013). Hence, there are additional references in the discussion chapter that may not have been referred to in this chapter.

I used narrative scoping reviews to undertake a comprehensive assessment of the literature to provide an overview of what is known about PPD in relation to RNs. That was suitable for this broad topic and allowed me to explore related literature (Munn *et al.* (2018). Peterson *et al.* (2017, p13) postulate that scoping reviews *'can serve as a richly informed starting point for further investigation'.* Aveyard (2104) states though the quality of evidence may not be the highest graded quality of evidence it can open 'a wealth of insight' on the subject. This included reviewing the grey literature from professional, governmental and NHS sources, exploring the concept and theories of PPD, Continuing Professional Development (CPD), and lifelong learning (LLL), which all added to my topic guide and outlined some of the key issues of WRNs' PPD (see Appendix C).

Moule, Aveyard and Goodman (2017) suggest that inclusion and exclusion criteria are used. The search was limited to articles written in English (the majority of SA research literature is published in English as well as any other SA national language). Dates were limited to articles published up to 20 years old. Punch (2016) argues that including papers over this age can be problematic in that the reader needs to be aware whether these are still current and applicable to the topic being reviewed. In this study, I believe that these older articles used in this literature were still credible texts to refer to, as they held findings and made valid points, and some gave a historical

perspective that needed to be considered when exploring the issues of PPD and undertaking a comparison between WRNs' experiences and perceptions from the two countries.

2.1 Conducting the search strategies used

Aveyard (2014) posits that the approach to the search is influenced by the research and sources that you are seeking that are truly relevant to the study. Hence searching for grey literature and articles relating to the key words were searched in the UK's and SA's governmental department of health websites, professional nursing bodies/unions and nursing regulatory bodies.

In the initial search key words used on the search engines were: CPD, Life Long Lifelong Learning (LLL), Personal Development Plan (PDP), personal and professional development (PPD), appraisals, development, education and training, and post-registration learning. This was repeated using 'and nursing'.

The electronic search engine used was called Quest, which carried out a cross-search of over 40 academic databases including Medline, Cinahl, Web of Science, and later, the One Search engine was used (University of Cumbria, 2011). Additional searches were carried out in key nursing journals.

The number of articles retrieved for the initial search was 1300. However, on further examination, many of these articles were on pre-registration nursing, which were discounted. Some of these articles were written by nursing academics about registered nurses studying on courses (academic, non-academic) or studying a speciality. Some of these were deemed to be unsuitable due to the lack of depth, the main debate being on issues specific to the nursing speciality, others were rejected because they did not refer to PPD and were more focused on the outdated assumptions of CPD. A minority of articles provided evidence that RNs were struggling to undertake PPD for a variety of reasons.

To conclude, at preliminary stages of the study carried out in 2011, having scrutinised the titles and abstracts, 27 papers were found to be relevant to the research study. This number of key papers increased as further literature searches were conducted using the same search strategy as before as part of the ongoing literature search in the CGT approach (See Appendix B for the flow diagram). These revealed articles written and published in 2013 and 2016 by scholars from the Netherlands, who wrote a series of papers reporting mixed methods studies on their RNs professional development, (Pool *et al*. 2013; Geurdes *et al*. 2016; Pool *et al.* 2016). Whilst it is acknowledged that the Netherlands has a different culture, health system, and employer approach towards professional development, nonetheless these papers provided some interesting insights (See Appendix B for the chart on the main key articles used in this study).

It needs to be noted that when this research study commenced, there was little information that could be found on SA websites or on research articles directly relating to SA. This necessitated hand searching for articles, printed thesis and dissertations within the SA university libraries that I had access to during my three trips abroad. Using the same search terms, conducting electronic searches using the SA universities' computer search engines revealed a small number of papers on this topic that had not been raised in the UK searches. The theses that I read did not contribute to the literature review, but they did help me understand issues that nurses in SA faced, for example the short staffing, lack of resources and pressures of nursing in differing environments from working at night in a public hospital, accident and emergency to community care and caring for those with diseases that are not so common in the UK.

On reviewing the literature and writing up this thesis in 2018, SA websites became much more informative than in previous years. Over this period, website links provided in the reference list that were accessible at the time of the search may not necessarily be accessible today, due to web addresses

being updated or changed. Often, my computer warned me that SA websites were a threat and unsafe to use. I had to exit from searches to avoid my computer becoming harmed; a computer virus checker and other safety measures are essential when opening the websites listed in the reference list.

Since commencing the study, I continued to carry out electronic searches and extended these using the key search terms, to alert me of new sources. I also used Google Scholar search engine to help search for further references and gain a broader understanding of the current issues facing nursing globally, as well as those in SA and the UK, which has led to a comprehensive reference list.

It was noticeable that there were significantly fewer articles retrieved on SA, than there are from the UK and worldwide. The SA unions that represent nurses were contacted to discuss the current concerns on RNs' PPD, though it was not clear why there were so few published papers on RNs' PPD in SA or other African countries. It could be suggested that RNs are more inclined to undertake research, based on the nursing care of patients than on nurses themselves. It was recognised that some references made in this thesis, with reference to the hierarchy of evidence (Aveyard 2014), will be judged as poor quality however these provided information and knowledge that was essential for this comparative study.

The research evidence from these SA and UK sources were reviewed using the Critical Appraisal Skills Programme (CASP) 10 questionnaire tool that has 3 sections: a) are the results of the study valid?, b) what were the results? and c) will the results help locally. Main key texts have been placed into a chart (Appendix B). The sources used for this study are mainly qualitative, small scale research projects published in journals that have been peer reviewed, or discussion articles written by experts in the field (CASP, 2016). A few of these studies included responses from

questionnaires. The majority of evidence was well designed qualitative research studies which was appropriate for the topic in this study and sits midway in the Hierarchy of Evidence, Moule *et al,* (2017). A few ranked at the bottom of the hierarchy being professionals personal experience and expertise, Munroe (2008), Narayanasamy and Narayanasamy (2007). Literature reviews and Delphi studies summarised what was already known from previous research and made recommendations that further research was required to delve into the complexities of PPD and to how these mechanisms interacted with one another. Studies with quantitative aspects were used to ascertain if statements founded on previous research and literature were agreed or not agreed by participants. No quantitative studies were found that could indicate to why RNs are not aware of who or how many RNs are supported by employers to carryout PPD activities. Most of the papers were focused on male and female nurses. Some were explicit in that they were based on RNs; others were based on nurses – they could have incorporated healthcare workers that hold a nursing qualification or not but none of these research studies focused primarily on women demonstrating a gap in knowledge with regards to issues that impacted on women. A very small minority of research papers discussed the results that they thought were relevant and related directly to women, and women's' lives though Beatty, (2001) was the only study that focused only issues that effected specifically women RNs. Therefore some of the issues that would be researched are those issues that affect women directly and in-directly and have an impact on their PPD. For example, the responsibilities they have in the home and the relationships with their partners and families. The study aimed to capture women's voices.

More recently, research studies from the Netherlands, have noted and discussed participants' details with regards to sex, age and number of years' experience as an RN (Pool *et al*. 2013; Geurdes *et al*. 2016; Pool *et al.* 2016). By declaring the average age and number of years' experience for

example in Pool *et al.* 2016 study they stated that the average age of nurse participants in their studies were 43 years old and the experience 12 years. This brings to light the gaps in knowledge on women RNs careers and the specific influence of age and experience that it has on shaping their PPD that further research is required that will also challenge assumptions made about women RNs wants and needs according the stage of their lifespan.

This literature review did identify studies that had been conducted by nurses working and studying in their own country, but no studies were found that compared WRNs' perceptions and experiences from two or more countries and so there is a significant gap in knowledge to how countries compare to one another. Since designing the research project in 2010/2011, several pieces of research and discussion papers have been published that offer further insight into the perceptions and experiences of RNs' PPD. This literature review is an amalgamation of searches conducted on all the literature reviewed to the present day, 2020. It should be noted in particular that the re-validation process for RNs in the UK was introduced after empirical data had been collected, and was not experienced by the participants in this study (NMC, 2016). In 2018, SA's SANC announced that they would be introducing a new re-registration process. At the time of writing, the exact details have not been released (SANC, 2018a).

This thesis has been written in the third and first person, to reflect upon my own knowledge and experience, and to critique the literature and identify any gaps in evidence (Webb, 1992). The issues raised are discussed using what Creswell (2003) describes as looking at the top to bottom approach, clarifying the terms used by government, and nursing stakeholders down to women as individual RNs.

The content of this literature review has been selected to aid comparison between SA and UK RNs and to explore literature that questions what WRNs' perceptions and experiences of PPD have been. This chapter is

supported by the background section on SA and the UK (see Appendix A) and the topic guide (Appendix C). The literature review begins by explaining how I conducted the literature searching that has been continuous since commencing this study in 2011 to the present 2020 It then moves on to explore to how Continuing Professional Development (CPD), personal development, professional development and Lifelong Learning (LLL) and nursing portfolios have all contributed to creating the term and theories of 'PPD' and its importance within healthcare today.

This literature explores why RNs engage in PPD, their motivation and reasoning, and how the changes in healthcare have impacted PPD, changing the level of support from employers to RNs. Responsibility has shifted more to the individual RN, and away from their employer. I reviewed what RNs thought the benefits were of PPD and the barriers that they experienced, particularly the difficulties of getting time to undertake PPD in paid working time, and getting funding to pay for courses, all of which can aid the RN's career development.

2.2 Four sections of the literature review

The literature review has been divided into four sections: PPD its origins and meanings, Engaging and recording PPD, Employers and PPD, and the challenges of undertaking PPD.

2.2.1 PPD its origins and meanings

This section aims to explore the term PPD that has been used more frequently by RNs. It could be suggested that PPD evolved from CPD and LLL. From the late 1980's and into the early 2000's the UK government set about its new approach to CPD. The Department of Health (DOH, 1999) defined CPD as a group of activities that supported the concept of LLL within healthcare. The RCN (2014) identified that there is no universal definition of CPD. For RNs, CPD is about being fit to practise, having up-to-date skills and knowledge and being able to respond to the demands of healthcare

service delivery and technological advances. Rafferty *et al.* (2015) argue that definition of CPD has been problematic, as it has ended up being a *"catch-all category"* from mandatory training to PhD studies. The Health Care Professions Council (HCPC, 2006) add that CPD involves a range of learning activities, to ensure safe and effective practice.

Wallace (1990) argues that RNs need to be clear if CPD is statutory, mandatory or permissive, outlining that statutory and mandatory trainings must be carried out, but the third – permissive – gives the individual choice. However, if RNs do not undertake these activities sanctions may be placed on them, by the employer and/or a professional organisation such as the nursing regulatory body.

The RCN (2018, p6) states that the employer may also offer what they term as *'developmental CPD'*. This is when the employer decides that they need to have staff with certain qualifications or training *'based on a need for particular services and the skills required'*, that the employer may commission training for staff. Hence, this developmental CPD is from what the employer wants staff to undertake, and not from the perspective of WRNs, who may have identified what developmental activities they need to undertake for their own personal or/and professional development.

The RCN (2014) state that the terms professional development, nursing education and LLL are terms used to refer to CPD; however, they did not mention personal development. The concept of lifelong learning was described as the individual realising their potential, taking the opportunity to grow, and acquiring new knowledge and skills, that would *"help shape and change things for the better"* (DoH, 2001). To be a lifelong learner you need a variety of skills: to be aware of the self, be able to reflect, to recognise the link between learning and life, to be motivated and seek learning opportunities, to able have study skills to access learning, understand the

nature of knowledge and be able to translate knowledge to support the delivery of high-quality nursing care (Wallace, 1990; Davis *et al*. 2014; Reyes, 2014). The United Kingdom Central Council for Nursing (UKCC, 2001) stated that nurses needed to adopt the *"principles and values of LLL"* to keep their practice up to date. A lifelong learner is argued to be someone who continues to learn new things throughout their daily lives. They transfer learning between their working and private lives (Maslin-Prothroe, 1997; Shepard and Bethell, 2008).

Changes in healthcare practice and services, along with continuing advances in technology, were also used to support and influence the need for RNs to become lifelong learners. Davis *et al.* (2014) establish that LLL avoids stagnation and means that people are able to evaluate whether what is happening fits within their own frameworks of understanding and professionalism. The SA Department of Health (DOH, 2007, p4) argued that by *'establishing a culture that values lifelong learning'* this will have an important effect on improving quality in healthcare.

It could be suggested that the concepts of employability and LLL became inter-related. The European Commission (1995) pressed governments to raise the profile of LLL, as changes were being made to industry that included potential redundancies for some jobs. On the other hand, as technological advances would result in the creation of new jobs, people would be able address these changes and continue to be employable if they approached these challenges using LLL skills. For the NHS to survive the financial challenges that it was facing by having to reduce operating costs, it had to warn RNs, who, though they were currently in stable and secure jobs, they could be facing uncertainty of employment in the future (McSweeney, 1996).

It was argued that CPD and LLL promoted skills and knowledge that would aid employability. Hull and Redfern (1996, pp13-14) argued that *"employers*

now demand and expect employees to be flexible, self-motivated, and able to transfer skills into new situations with ease". Hence, for RNs to remain employable in addition to their nursing knowledge and skills gained from completing their pre-registration nursing qualification, they were now being told that they had to take responsibility for becoming lifelong learners and continue to develop their knowledge and skills as qualified RNs. The DOH (2001) document *Working Together, Learning Together: A Framework for Lifelong Learning in the NHS* argued that it needed staff to be more flexible by creating a learning culture that supported CPD and LLL. What was clear was that government and the NHS encouraged the development of the philosophy behind LLL and linked it to CPD, complementing each other (Bethell and Sheppard, 2008). Stakeholders affiliated to healthcare professions supported this and the nursing profession embodied this concept into the role of the RN.

The International Council of Nurses (ICN) support the concept of PPD, reminding us that the RN holds an important professional role within society and healthcare, and that RNs' job roles are continuously changing to meet the ever-increasing demands of healthcare (ICN, 2007). What is clear is that the ICN argue that for RNs to be able to perform within their scope of professional practice, RNs need to have access to education and training that this CPD needs to be provided by the employer (ICN, 2001, 2009b). The RCN (2017e) agrees that there is a clear need for the continuing development of RNs' nursing competence and expertise. That life-long learning (LLL) for RN's is essential as it incorporates both personal and professional development (PPD).

2.2.2 Engaging and Recording PPD

This section explores the requirements of RNs to engage and record PPD. NHS employers and private healthcare employers in both SA and the UK argue that the RN's role includes being able to deliver and manage quality

care and that RNs' PPD activities serve to maintain standards and can support improved quality in healthcare (Department of Health, 2007; National

Quality Board (NQB), 2016; World Health Organisation (WHO), 2016; Care Quality Commission (CQC), 2018). These healthcare providers report on the standards of each healthcare organisation. Each organisation (employer) must record training and education that it provides for their employees for the purpose of audits and inspections.

The WHO (2016a; 2016b) stressed that to run healthcare services and to be able to adapt and respond to changing healthcare demands, healthcare providers must be clear on what they require from RNs, given the new and developing roles that RNs are now undertaking. Employers need RNs who are safe and able to work within their scope of practice and produce quality care (Rafferty *et al.* 2015) resulting in: (1) achievement of set patient outcomes, (2) the delivery of healthcare standards, and (3) the process of the employer recording employees' qualifications and PPD activities. This recording is required as evidence of standards for audits and inspections that are carried out by governing regulatory bodies (Wells, 2007; WHO, 2016a, 2016b; SANC, 2016). By undertaking development activities, it can result in improvement of RNs' knowledge and skills, perceptions and attitudes (Gijbels *et al*, 2010). In addition to these mounting pressures, worldwide, RNs have had increasing expectations and pressure placed on them, to engage and record their developmental activities (Hull and Redfern, 1996; Jasper and Mooney, 2013). Hence, there are increasing demands on the roles of RNs and, concurrently, increased demands for PPD in order for them to conduct these roles effectively and efficiently (RCN, 2018).

Exploring RNs' perceptions and experiences of PPD Hughes' (2005) UK research on nurses' perceptions of continuing professional development, that involved the analysis of over eighty questionnaires and four in-depth interviews, identified eight key themes (see Figure 1 below). However, there

is no indication whether the components that sit within each theme are more important than others. The study only addresses professional development, with no reference to personal development but does give an insight in to what nurses valued about professional development; for many, it was a means of progressing their careers. This may explain why nurses still undertake professional development, despite the barriers they face.

Figure 1 Hughes (2005, p45) How nurses perceive the benefits of continuing professional development to practice.

2.2.3 Why RNs engage in PPD

Researchers based in the Netherlands carried out a range of research based on the concept that CPD is influenced by three components: RNs' motives in doing CPD, the importance RNs place on CPD, and the conditions that RNs feel are needed to be able in engage in the activity (Brekelmans *et al*. 2013; Pool *et al.* 2014; Brekelmans *et al.* 2015; Berings *et al*. 2016).

Brekelmans *et al.* (2015) study discovered that nurses whom had motives relating to career opportunities were found that after having undertaken PPD, to experience an increase promotion opportunities, to achieve a higher level of training, to support their career and to improve leadership abilities. RNs viewed their requirements to engage in PPD to be related to increased promotion opportunities, achieving a higher level of training and to carry out CPD because it was seen as important in the environment that they worked in. Pool *et al.* (2016) explored the relationship between motivations and the developmental activities that RNs undertook from a different angle. They asserted that there were nine motives identified. The first two most common motivations found were the wish to increase competence. This was based around nurses knowledge and skills to carry out their job roles, and links directly to their role as an RN, along with complying with employer requirements to engage in mandatory (core) training. The third motivation appeared to be linked with both personal and professional development, described as needing to deepen knowledge, stating an intrinsic desire to know more and some nurses planned to undertake postgraduate education. The fourth was to enhance career development and was mainly related to the desire to undertake postgraduate education. The third and fourth motivations appear to be strongly related to achieving academic qualifications that could lead to career development.

Pool *et al.* (2016) stated that the remaining motivations were raised less than the one's referred to above. These were: for RNs to get relief from routine, that new challenges and new learning 'makes you grow', to improve

healthcare by learning about updates. To increase self-esteem, in that by having more knowledge, RNs were able to answer questions from patients and students, to supplement gaps in previous education and to build a professional network, to have contact with other nurses working in the same area. It was noted that these remaining motivations were all of a much more personal nature, which may be why they were not mentioned as commonly as the professional goals. These motivations differ from the reasons for undertaking professional development found in Hughes' (2005) UK study in which the order of commonality were more related to professional and work-based related reasons: improving care, practical skills, career prospects, enjoyment, have to do it, paid for, sent on it, availability, get day off, and 'other' – which was not explained. These studies suggest that there are professional, personal and work-related reasons and motivations for PPD engagement, all of which build upon RNs' experiences and perceptions of PPD.

It seems that the key reasons reported as to why RNs undertake PPD are focused mainly on professional reasons related to the RN's current job and future jobs. One positive aspect is when CPD is "linked to the notion of reward*"* that the activity will benefit the nurses' development (Rego and Pina e Cunha, 2009). Wallace (1990) argues that the perception of CPD for the individual can vary from being implicit, rather than explicit; hence something that they personally wish to do, rather than being made or expected to do. Hence, CPD can be perceived and experienced as being negative or positive for the WRNs depending on the reasons why they have to undertake these activities. It could be suggested that this is what makes CPD distinct from PPD. CPD is often undertaken in the workplace, being stipulated as mandatory by employers. CPD consists of activities that have to be undertaken to be able to practice and/or create and produce evidence to continue to practice as an RN. Whereas PPD can be something that the woman RN personally wishes or aspires to do.

2.2.4 PPD aiding women's social mobility

In the UK, the nursing profession is a predominantly female profession; only 9% of nurses are male (NMC, 2015). Many women have already accepted that working in this predominantly female profession results in a lower wage in comparison to other professions (All-Party Parliamentary Group on Global Health (APPG) 2016b). In SA, 2016 figures indicate less than 1% of RNs are male (SANC, 2016b)[1]. The ICN (1999) have raised the socioeconomic welfare of nurses as an issue challenging social justice, arguing that 'women's jobs' are seen as having lower market value; hence, pay could be 15% lower than male dominated jobs (ICN, 1999). There is an increase of female-headed households, challenging the traditional concept of the male being the breadwinner of the family (Department of Women, 2015) and more women who have the choice, choose to remain single.

Yet undertaking education/courses/activities as part of PPD could have a potential impact on increasing women's social mobility. Women with qualifications and training have been able to access jobs that require higher skills and are better paid than low skilled jobs (Office for National Statistics, 2013). Social mobility results in higher status or economic status, which has become more essential for women in today's society, (Betz, 2005). The RN qualification leads to employment in jobs that are regarded in SA and the UK as medium to high skill jobs. Hence, by women gaining nursing qualifications and studying for further qualifications and engaging in PPD activities, they are able to earn a better wage than women working in non-skilled jobs. Many healthcare employers (public and private) offer more benefits, such as pensions and sick pay, unlike other employers who may not offer this or, in

[1] However, there are males working in other nursing roles as enrolled nurses (in both the UK and SA), auxiliary nurses (SA) and as healthcare assistants or assistant practitioners (UK) (SANC, 2015).

SA, much low skilled women's work offers no contractual agreement or security (Department of Women, 2015).

It could be argued that the costs of daily living and women's roles in society often result in them having caring responsibilities for others in families (traditional and nuclear) have also had a negative impact on women's opportunities to engage in PPD activities. Roles that women take outside the working environment are argued to reduce women's finances and reduce time to undertake PPD activities (Casale and Posel, 2002; Womens Resource Centre, 2013; Department of Women, 2015). Paying for PPD activities is one of the difficulties that WRNs face. For many women, caring and home responsibilities take up much of their time outside paid working hours, reducing opportunities to spend time in engaging in PPD activities outside of paid working hours (WHO, 2016c).

Women's societal roles may be one of the barriers against engagement in PPD. Given that professional development can be a requirement for re-registering on a nursing regulatory body's register, nurses risk not being able to work as an RN if they have no evidence of PPD (this depends if the regulatory body has stated this as a requirement: this is the case for UK and SA RNs (SANC, 2018a; NMC 2015a, 2015b, 2018). Furthermore, by not undertaking the training, and/or engaging in other PPD activities, the RN is no longer up to date with current practice.

The risks of not undertaking PPD activities can result in a number of issues, primarily that without proof of registration RNs will not be able to work or be employed to practice as RNs. Employers can now access and view RNs' individual registration status via the nursing register, so there is no room for any misunderstanding (Gray 2014; NMC, 2015, 2017; SANC, 2016a).

Without engaging in PPD RNs run the risk of becoming stagnant in their job roles, being unable to re-apply for their current job roles (often due to re-

structuring) and being unable to apply for higher graded job roles because they may not have achieved the PPD activities that are stipulated on the job criteria.

2.2.5 Changing approach towards RNs' development

As the health service changed to meet demands, McSweeney (1996) warned that previous career paths that planned a step by step progression have gone. It could be argued that LLL promoted the concept that it was now RNs' personal responsibility to develop themselves further, and if they did not, they could be 'left behind', with reduced career and employment options. The responsibility of employers offering opportunities to develop began to change.

Developing RNs was no longer just the employer's responsibility: the individual RN now had to take personal action and responsibility as a professional to motivate themselves, to grow, develop and acquire new knowledge and skills, in whatever way they could, such as self-directed learning, so that this would benefit themselves personally as an individual as well as in their role as a professional (Davis *et al.* 2014). McSweeney (1996) reiterated this by stating that if RNs did not gain support from their employers to undertake study on formal courses, which Shepard and Bethell (2008) highlight was the approach used by many RNs to be promoted or move into a specialism, then RNs must invest in themselves, by using their personal resources. This included time and money to undertake these courses.

Within the NHS and other healthcare employers there has been a changing approach to managing CPD, persuasively arguing that they had to do this, in order to sustain healthcare in challenging fiscal climates. It could be suggested that it gave them the option to disengage, from taking full responsibility in supporting all types of CPD activities. Employers' short term goals to commission training and development for staff to support the current

service needs may not encompass the individual RN's long-term PPD needed to develop their careers (Rafferty *et al.* 2015).

The RCN (2014) stated that the NMC expects employers to support RNs in undertaking CPD activities. However, there is no legal obligation to do so, even though it is recommended that employers negotiate a protected time agreement with RNS. The RCN's (2014) survey revealed that out of the 10,000 nurses who participated, for those who answered the question on support from the employer, 10% replied that they had no support from their employer to fund development activities that involved studying on courses – though it was not clear if the remaining 90% had requested or received support and, if so, which types of courses these were (for example, 1 day or a 3 year Masters) . The RCN, 2015 employment survey, which had 4,137 respondents, stated that 1/3rd had no CPD provided or paid for by their employer (RCN, 2015a). This clearly demonstrated that RNs in the UK are experiencing a lack of support from employers. Thus, RNs are struggling to gain access to developmental activities within paid employment/paid working hours and, because of this, it could be suggested that RNs are having to resort to self-fund and find other types of support themselves. Thus, it could be argued that personal and professional development has become more prominent for RNs who have had to guide themselves in their career development, rather than relying on employers (Rafferty *et al.* 2015).

2.2.6 Formal and informal Development activities

Pool *et al.* (2016) argue that development activities are often split under two definitions: formal and informal. Formal PPD activities have been referred to as the deliberate planned undertaking study on educational courses that may or may not have accreditation attached to them and/or lead to gaining academic qualifications, such as those delivered in the university settings. Informal PPD activities could refer for example to core training that can be termed as 'mandatory', 'in-house' or 'in-service' training delivered, designed and funded by the employer; including teaching sessions and informal study

sessions, shadowing, being mentored or supervised, being taught and given the opportunity to learn and develop knowledge and skills whilst undertaking the job. Pool *et al.* (2016) expand on this, in that activities can be implicit or incidental learning that takes place, and sometimes the RN is unaware that learning is taking place.

Many courses are no longer being delivered by the hospital, and instead are being delivered by other stakeholders, such as universities. Formal activities are often made in reference to courses, which often need time and funding. Whereas informal activities are often found to be activities that can be delivered and carried out within the workplace; this also includes learning whilst undertaking the job.

The UK document *Continuing Professional Development Quality in the New NHS, (1999)* argued that CPD needed an updated approach, blatantly stating that *"not all CPD leads to an academic qualification"* and that CPD "*included much more than going on a course"* (1999, p10). Shifting the focus on to other forms of informal CPD activities would be less costly for the employer and easier to manage, as they would have fewer staff requiring absence from the workplace to attend these courses. RNs were not being told by the NHS they would no longer offer support for any courses; what it was saying was that the responsibility for study and completion of courses and other costly formal development activities would no longer be solely the responsibility of NHS employer (McSweeney, 1996; NHS, 1999). It was apparent that the term 'CPD' started to change, as new concepts had been added into it (Perry, 1995).

Hence, formal development activities, such as courses that were viewed by RNs as highly valued and essential because they gave RNs the opportunity to further their knowledge, skills and career development (Brekelmans *et al.* 2014) were no longer going to be considered by the NHS and other healthcare employers as the main CPD activity for healthcare professionals

that the employer must support (NHS, 1999). The RCN's (2018) report on CPD for RNs in the UK highlights that, in England, over the past two years, budgets for staff development have been cut by 60% and less funding is being offered for RNs to study on university courses/ modules. Hence, employers have reduced CPD budgets, which has led to more emphasis on PPD, as RNs seek to develop themselves and their careers. They have had to undertake Personal Development Planning (PDP) to plan their careers.

The RCN (2018a) argued that CPD "should" expand beyond influencing the care that RNs give, their aspirations, career development and earning potential. Whereas it could be suggested that they are stating that this is one step further than CPD; this is, in reality, PPD.

Changes that employers have made in their approach to CPD have led to an increased focus on PPD and less on CPD. For the responsibility of undertaking developmental activities now lies far more heavily on the individual, and rather less on the employer. It was during the late 1980's and early 1990's that these references to LLL, CPD, PDP, self-directed learning and career development planning became familiar to RNs (Wallace, 1990). They were also associated with being, personal development, professional development and PPD. Yet, the gap in the knowledge is that none of these offered clear definitions of what these actually were, or how or why personal development was separate to professional development, or when personal and professional development became joined together, and why. The ICN, (2001) stated that personal and professional development is key to developing nurses and their careers, but once again what they did not do is stipulate exactly what they defined PPD to be.

Brown (1995) offered some direction on what PPD is, stating that to carry out PPD you need to set personal and professional goals, which fall into two separate categories. The first category being the goals that the individual sets themselves. The second being the goals have been negotiated with, or

imposed by, other individuals or organisations. The latter appears to apply more to what was traditionally viewed as CPD, whereby the employee undertook training and development within the workplace during paid working hours that was supported by the employer, e.g. funding and time. Whereas the goals that the individual sets may be personal, as well as professional, but may not be connected with the current job role or employer. Personal development could be more focused on career goals or ambitions to complete academic studies. These goals may or may not be related to the RN's current job role. Hence, personal development is more than likely to be initiated by the individual themselves, rather than by the employer (Munroe, 2008). The definition of PPD in the literature remains unclear and varied. The working definition was that PPD incorporated both personal and professional development. What is known is that professional development can influence personal development and vice versa. What is not known is what women RNs perceive or experience the ways in which the personal and professional interact with each other.

2.2.7 Employability and PPD:

Narayanasamy and Narayanasamy (2007) argue the contraction of nursing posts and reduction of jobs at higher grades has led to an increase in competition for nursing jobs. This has changed the RNs' experience of work, both in the UK and worldwide. RNs no longer work in cultures where the loyalty of working for an employer for a period of time is rewarded, or where they are guaranteed a *"job for life"* (Timmins, 1994). This contraction in the number of nursing jobs also includes a reduction of jobs at a higher grade (Narayanasamy and Narayanasamy, 2007). Cottrell (2015) argues that, like many graduates, the individual needs to draw upon a range of skills, knowledge and attributes, and continue to develop these as part of their ongoing development to remain employable. This contributes to success in their current and future job roles. Hence, because of the issues of employability, WRNs cannot rely on CPD activities provided by their

employers. Instead, they now need plan to undertake their own PPD activities to remain employable.

2.2.8 Recording of PPD activities no longer just the employer's responsibility:

The introduction of qualificatory frameworks, pay scale frameworks and occupational standards has created what Shepard and Bethell (2008) describe as a common language and shared competencies across healthcare. This may have also influenced the perception of PPD, in that it requires a constant recording of this information with regards to training and development, job specifications and experience, and an increase in higher academic qualifications (specialist qualifications, and qualifications at degree, Masters and PhD level) for some higher paid job roles.

For the purpose of audits and inspections, the employer has an obligation to record the CPD activities, maintaining a database for inspections carried out by independent organisations that inspect to ensure that standards are being met (Department of Health, 2007; NQB, 2016; Care Quality Commission, 2018). (In both the UK and SA, RNs can be employed by nursing agencies and NHS or private hospital banks; these employers also expect their staff to demonstrate that they have undertaken the equivalent of the core training (statutory and mandatory), as this forms part of the employment contract).

However, there is an increasing need for RNs to take more responsibility to record their own PPD activities for the purposes of appraisals, application of new jobs, career development, and re-registration or re-validation (including a responsibility to pay fees and complete the required documentation).

Training, education and recording of PPD activities are in the interest of both the employer and the RN. The employer only needs evidence of CPD activities that RNs have engaged in, whereas the WRNs who wish to remain registered and able to practice and to develop their careers need to record

their PPD activities to demonstrate continuous development of themselves and their professional development (NMC, 2015a; SANC, 2018b).

The employers' change in approach to CPD has led to the growth of PPD becoming a more commonly used term. CPD is directed primarily by the employer whereas PPD is a far wider term, which incorporates both personal and professional development that demonstrates LLL and supports and enables preparation for employability and career development. At present, there is no one definition of PPD. However, PPD is necessary for all WRNs working in today's challenging healthcare environment.

RNs using and demonstrating their knowledge, skills and development for nursing regulatory bodies, employers and for themselves

The use of the nursing portfolio, and re-registration (or re-validation) is important aspect of engaging and recording PPD. Jasper (2006) suggests that there are a number of contexts that inform development (as per the model below, Figure 2), that each section in the model contributes towards the professional development of the RN. It could be argued that portfolios and reflective writing have been regarded as the two key activities that influence professional development and can also feed into their PPD. However, Jasper has ignored many of the personal aspects of development that go hand in hand with many of the activities in her model, such as clinical supervision and reflection, that require the individual to be self-aware and reflective (2006).

Figure 2 Concepts of informing professional development, Jasper (2006, p3).

2.2.9 Nursing portfolios and personal and professional development:

Shepard and Bethell (2008) remind us that up until the late 1980's there was no requirement for RNs in the UK to engage and record CPD activities.

Hibberd (2008) asserts that the portfolio was first introduced by the nursing regulatory bodies, and the aim of this was that it would provide evidence that demonstrated professional self-regulation and practice within the RNs' role boundaries and their code of conduct. The UK's UKCC (1994) stated that as part of their Post Registration Education and Practice (PREP) requirements all RNs had to have a Personal Professional Profile (PPP) consisting of evidence to demonstrate that five CPD days had been undertaken, which had contributed to maintaining professional knowledge and skills (UKCC 1994). This portfolio may be reviewed at the three year re-registration point on request from the UKCC (UKCC, 1994; Hull and Redfern, 1996). The NMC (2015b) introduced a new re-registration process, whereby to re-validate RNs

have to show evidence of reflection on practice, that RNs are no longer expected to have a portfolio that they could be asked to present, but it does not indicate if RNs should continue to have portfolios. Hence, RNs may continue to keep portfolios for nursing literature and the UK NHS still supports the concept of having a portfolio (Rosser, 2013; NHS, 2018; NMC, 2018). Whereas the SANC are now introducing the requirement for RNs to have a portfolio and require the RN to record CPD points (SANC, 2018b).

The introduction of a portfolio raised three key issues: what aspects of CPD and PPD evidence is required and for whom is it being produced for? The quality of the evidence, and least questioned, when and where should the RN undertake activities and use time to compile their portfolio?

> Hull and Redfern (1996), though dated, make some relevant points. They argued that the differing titles brought about much confusion, as the UKCC described the profile as being a personal professional profile, whereas the

ENB called it a professional portfolio (ENB, 1991, 1994; UKCC, 1994). They argued that these terms, personal and professional, and other terms associated with CPD and LLL, had been used *'interchangeably and often inaccurately'* (Hull and Redfern, 1996, p4). This had led to many suggestions and debates questioning exactly what personal development, professional development and PPD is. What did happen here, was that both the NMC and ENB chose to place PPD prominently onto the nursing agenda, without offering a clear definition of what PPD was. They encouraged a portfolio of evidence that could have included evidence of both personal and professional development.

2.2.10 What is the quality of evidence required in a portfolio?

Jasper and Rosser (2013, p154) argue that the evidence for a nursing portfolio can range from the lowest quality being a *'shopping trolley model'*

whereby certificates for attendance on courses and photocopies of handouts are collected in a folder, along with the dates and number of hours. Critique of this style of portfolio is that proof of attendance of trainings may not necessarily demonstrate application of knowledge into practice; this may be dependent on the WRNs' perception of PPD. The shopping trolley model could be easily achieved if the RN is able to engage in mandatory trainings that are provided by the employer.

Jasper and Mooney (2013, p103) claim the portfolio can be used as a *'development tool for professional development'* and that it allows exploration and learning from practice. They suggest that it can develop analytical skills and *'enables personal sight and growth'* with regards to action planning, changing and improving professional practice. Munroe (2008) adds that it should be used to evidence personal and professional LLL and as a development and planning tool used to review career development, as well as professional and personal goal setting. Jasper and Rosser (2013) argue a higher quality portfolio will demonstrate evidence of the RNs' development, for example, Curriculum Vitae (CV), attributes, evidence of past achievements, planning for future development and reflection. Hence, this could be argued that it steps away from what CPD evidence could consist of, and moves towards evidence that demonstrates PPD. Jasper and Mooney (2013) lend support to this higher quality portfolio by stating that when the RN is creating evidence such as reflections on their practice for their portfolio, they cannot ignore PPD. For '*coexistent with professional development is the category of personal development, and it appears that these two components exist in a direct and dependent way, in that one will not occur without the other*' (Jasper and Mooney, 2013, p103). Hence, bringing us to conclude that by creating a high quality of evidence in portfolios the RN is producing evidence that demonstrates and contributes to their PPD.

Reflection and reflective writing are argued by nursing academics to be one of the highest quality of evidence to be used in the nursing portfolios. Jasper

and Mooney (2013) refer to Jasper's (2004) reflective model, that has core and main categories. Two of these main categories are termed as professional development and personal development; the others are based on evidence of accountable practice, critical thinking and outcomes for clinical practice. Hence, reflective writing is argued to be essential evidence in a portfolio, as it is of a much higher quality and captures both personal and professional development.

The quality and type of evidence used in a portfolio is also dependent on what it is being used for, as portfolios have become a means to assess progression (Norman, 2008). The introduction of Personal Development Planning into university education was implemented by the Quality Assurance Agency for Higher Education (QAA, 2001) who also promoted the idea of students having a Personal Development Plan (PDP). The QAA stated on their webpage that it *'expects all universities to use the progress file initiative to ensure that students undertake personal planning throughout their time as undergraduates'* (QAA, 2001). They directed students to provide a progress file that evidenced the undertaking of Personal Development

Planning, to demonstrate that they were meeting these targeted outcomes (Cottrell, 2015; QAA, 2011; Cottrell, 2003). The progress file has been named as Personal DPs or as professional profiles. Personal DPs aim to have students reflecting and evaluating on their own performance, as part of LLL skills (Cottrell, 2003). UK educational policy supports the creation of electronic portfolios (e-portfolios); thus, student nurses currently studying at university are more likely to be familiar with portfolios and may be more attuned to using the e-portfolios that NHS employers (NHS, 2018) have provided for its staff.

In 2004, the UK's NMC introduced Standards of Proficiency for Pre-Registration Nursing Education (2004). Which were updated in 2010, it had four domains (NMC, 2010a), naming one of these domains as the Personal

and Professional Domain (NMC, 2004). In which it expected student nurses to present evidence throughout their training and at the point of registration to be able to identify their own personal development needs and develop their own personal development plan*, 'which takes into account personal, professional and organisational needs'.* To contribute to learning, demonstrate leadership, maintain safe practice, and to recognise and take action to *'meet any identified knowledge and skills deficit likely to affect the delivery of care within the current sphere of practice' (2004, p5)*. What this stipulation did do was place PPD firmly as something that must be carried out by student nurses through measurement of competency and standard learning objectives. Though there was no evidence to suggest that students had taken this approach forward into their post-registration or if this had an impact on their perception of PPD. It needs to be noted that these standards were replaced in 2010, with no equivalent of the above domain (NMC, 2010a). Thus, personal development needs of the individual had once again disappeared from view.

The NMC also offered guidance on creating portfolios and using e-portfolios for re-validation (NMC, 2018). The NMC also required a portfolio of evidence for RNs who wish to mentor students (NMC, 2008). Other portfolios have also been used as a means of academic assessment to demonstrate the achieved competencies and learning outcomes (Norman, 2008). The NHS recommends that, for staff assessment for the Knowledge and Skills Framework (KSF) portfolio could also be used (NHS Scotland, 2018a).

Hence, the quality of evidence required differs according to the use of the portfolio. This, in turn, could affect RNs' perceptions of PPD activities.

2.2.11 When and where should the RN undertake activities and whose time is used to compile their portfolio?

The UKCC did not make any agreement with the government or employers that they needed to give their RN employees time to compile their portfolios

within paid working hours. Hence, it could be argued that portfolios were deliberately not named CPD portfolios for this exact reason. It could be argued that PPD stepped clearly into the personal nursing arena and away from the employer's responsibility of providing time and resources to create a portfolio. In this literature review, no evidence was found on the time spent (inside paid working hours or outside), monies and efforts required for nurses to undertake this PPD activity. No comparative research has been undertaken to support that nurses who have a high-quality portfolios are more active in PPD than those that do not have a portfolio. No literature indicates if higher quality evidence (such as providing a reflective statement that requires concentration and time and is carried out in unpaid working hours), is more taxing than attending a teaching session. One could argue that it is hardly surprising then if the shopping trolley model is used by RNs, as this can be achieved in paid working hours and is the quickest way to compile a portfolio.

Maslin-Prothroe (1997) argued that those RNs who did not display knowledge and skills of being a lifelong learner risked not being able to re-register, as they would not have the evidence to present a portfolio that demonstrated that they were up to date with their practice. A flaw in Maslin-Prothroe's (1997) statement is that regardless of whether the RN has LLL skills, if the RN is unable to undertake mandatory training, or any other developmental activities, then they are at risk of not remaining up to date with current practice. This is due to their employer's actions, and not necessarily anything to do with the individual's actions. What could be used to support Maslin-Prothroe's (1997) statement on LLL is that an RN who is proactive in self-regulating and planning their future career can use their LLL skills to seek other ways to gain evidence. Those who rely solely on employers to provide opportunities to provide training risk not developing themselves and could risk disciplinary actions by conducting out of date practice.

2.2.12 Portfolios: do they result in a portfolio for the individual and/or planning for future PPD?

Hull and Redfern (1996) clarified in their book *Profiles and Portfolios*, that if an employer or the UKCC/NMC had requested to see the portfolio, then the RN could remove any personal information before submitting it, such as personal contact details. Yet, it failed to highlight evidence that could have been seen as personal and professional, that could risk conflict between the individual and the employer. For example, the RN's planned career pathway, which might not involve working with the current employer. The NMC revised PREP standards indicated in more detail than the previous version (UKCC, 2001b) by stating in its guidance that RNs had to record their CPD activities within a portfolio, and that if requested by the NMC, the RN would have to present the portfolio for review (NMC, 2004a). However, it was questionable how many RNs were asked to present their portfolio. These figures were not published; thus, it is debatable how many RNs had indeed complied a portfolio and presented a portfolio that demonstrated PPD.

On commencing this study, no portfolio of evidence was required by SA RNs (SANC, 2016a). The only evidence that they need to provide is proof of their nursing qualification from their training provider (Rispel and Armstrong, 2015). It has been clarified that portfolios will be introduced as part of their new CPD system (SANC, 2018a). Despite not having portfolios as a requirement by SANC, it is unclear whether some SA RNs had been encouraged (through nursing literature and nursing educators) to create a portfolio as a means of undertaking PPD activities (Hibberd, 2008; Norman, 2008; Shepard and Bethell, 2008; Rosser, 2013). Little is known about the motives of SA RNs in developing portfolios or indeed whether they do actually complete them or not.

It could be argued that the varied use of nursing portfolios by nursing regulatory bodies, employers and universities have encouraged a higher quality portfolio. Encouraging portfolios to move to being professional records

of development as well as personal development, as many portfolios now require demonstration of reflective writing, requires the nurse to reflect both personally and professionally (Dooher, 2008; Timmins, 2008). What portfolios have done is flexed RNs' understanding and perception of what PPD is and emphasised the need to record their development. It has also been used as a tool for aiding the planning and achievement of development. Narayanasamy and Narayanasamy (2007, p384) propose that, due to the changes in the healthcare environment, *'only the well-qualified staff with an impressive portfolio of staff development are likely to climb the career ladder'*. Hence, those that do not engage in portfolio development may be reducing their chances of career promotion.

2.2.13 Re-validation (UK) and CPD schemes (SA)

Since commencing this research, some nursing regulatory bodies such as the UK's NMC and New Zealand's Nursing Council (NCNZ) have taken a further step in regulation by introducing what they term as a competence assessment or a re-validation process. For RNs in the UK to maintain their registration, they must undertake a three-yearly re-validation process; successful re-validation results in them being able to re-apply for registration. This process involves completing the validation documents, which demonstrate that CPD has been undertaken in the form of reflective writing, and that the minimum number of hours of CPD has been achieved. This evidence can be stored in the RN's portfolio, which is now optional (NMC, 2015a; Nursing Council of New Zealand, 2017).

It could be argued that the introduction of re-validation and CPD schemes (SA) for RNs and the requirement for re-validation have increased the need for RNs to be engaging and recording PPD activities, as these demonstrate that their practice remains up to date. It is the individual RN's responsibility to undertake development activities and provide this evidence for review (RCN,

2017e).[2] In 2016, the NMC discontinued PREP standards and replaced it with re-validation standards (NMC, 2015a) stating that RNs may have a professional portfolio, and that some of the evidence may be used to support evidence for re-validation (NMC, 2018). Thus, evidence of re-validation is most likely to be stored in the RN's portfolio. In SA, the SANC are currently introducing a new CPD system that will require, again, a collection of evidence to satisfy its system of counting up CPD points required to register and for yearly re-validation (SANC, 2018a).

The UK's re-validation evidence must demonstrate CPD, with reference to PPD. The evidence required is the number of hours worked (to reach minimum requirements) and five pieces of reflective writing that demonstrate safe and up to date practice and how this has related to an aspect of the NMC Code of Conduct, with the choice to suggest future development needs/plans. A named RN acts as the recorder, who confirms that all of the requirements of re-validation have been met (NMC, 2015a). What it doesn't state is that the RN has to refer to PPD; nor does it say that the quality of reflection required needs to relate to PPD. It only refers to sections of the NMC Code. Hence, re-validation points more towards CPD evidence being required than PPD which could compound RNs' perceptions of what PPD is.

2.2.14 Employers and PPD

As healthcare practice and the regulation of healthcare training, qualifications and professional practice and nursing roles have evolved stakeholders have been powerful in devising processes and creating definitions, meanings and concepts around PPD and its associated terms, according to what they wish the outcomes of PPD to be (primarily aimed at achieving their own set

[2] The SANC continues to face challenges and criticism in its administration procedures, and approach to nurse education (Rispel and Armstrong, 2015). Information on the website has been hacked several times, causing confusion about registration, payment and regulation (SANC, 2017). There is general criticism about the way in which the SANC manages nurse education and training (Rispel and Bruce, 2015; Oxford, 2016).

standards of safe and quality patient care) (Rosser, 2013; NHS England, 2015). The requirements for RNs to record, undertake and engage in PPD activities are clearly justified. Six main systems are in place to manage RNs' performance and PPD. These are: national pay frameworks: SA's Occupation Specific Dispensation (OSD) and the UK's KSF, personal development plans, appraisals, protected study time, bonus payment systems and nursing career frameworks (see Appendix A for background information).

2.2.15 SA and UK national pay frameworks aligned with an appraisal and development plan

RNs working for the UK or SA NHS share the commonality that they are employed under a national pay framework structure that offers a standardised system of pay, terms and conditions for all staff employed in the NHS. The incremental pay scale is designed to work alongside the yearly appraisal system, whereby the line manager assesses the competence of the individual RN against the job description and knowledge and skills framework.

Appraisals are argued to be integral to PPD in that the appraiser is able to use their knowledge and experience to guide the development of the appraisee (Narayanasamy and Narayanasamy, 2007). Healthcare employers have also made changes by creating pay frameworks that require evidence of PPD (Department of Health, 2004; Fouché, 2007; SA Department of Information, 2007; Public Health and Social Development Bargaining Council, 2007; nhsemployers.org, 2016). They now have job specifications that request evidence of PPD (informal and formal) within criteria that are listed as essential and desirable. The RCN states that the Agenda for Change introduced the biggest overhaul of the NHS terms, pay and conditions over the past 50 years (RCN, 2017b; NHS, 2016). The **SA** previous pay system was also radically overhauled and replaced by the Occupation Specific Dispensation (OSD) (Public Health and Social

Development Bargaining Council, 2007). Marks (1994) argues that the previous pay scale was discriminatory and influenced by apartheid rule. It gave higher wages to whites and Indians, with blacks earning less pay, ignoring the individual's knowledge and experience. Both of these UK and SA pay frameworks are designed with similar principles in mind in that they offer a clear process that outlines payment levels for their employees, linking it to knowledge and skills required for the job role. Hence evidence that can be stored in a PPD portfolio can be used in appraisals. However the disadvantage is that these only stipulate specific evidence, disregarding activities that contributes to both personal and professional development.

In the UK, there is no legal requirement for employers to provide protected time for PPD-related learning. This leaves RNs to having to negotiate with employers to have paid time to undertake PPD activities (RCN, 2014). In SA, the Department of Health (2011) introduced three days per year of protected learning time, often referred to as CPD "exam day". However, it is debatable how many RNs actually have access to use this protected learning time, as there are no figures available in the public domain to demonstrate that the implementation of this policy has been successful in supporting RNs or having an impact on recruitment and retention issues. Thus, RNs experience and perceptions of getting permissions to carry out PPD activities in paid work time may be varied.

There are two differing approaches towards creating and using NHS Personal DPs for RNs' development: the NHS Personal DP and the individual RN's PDP. NHS Personal DPs were introduced by the UK NHS in 2001 and in the SA NHS in 2007 (Department of Health, 2001; Government Information, 2007a; Jasper and Mooney, 2013). Both countries' NHS presented the Personal Development Plan as a tool that is completed by the employee (from any healthcare background, profession or level), to discuss and agree on goals with their manager, that would accompany the new

appraisal system and pay framework (NHS, 2004b; Government Information, 2007a).

The UK DOH stated that the purpose of the Personal DP would be to identify *"the individual's learning and development needs and interests and how these will be taken forward"* (DOH, 2004, p1). It could be suggested that this is open to misinterpretation by RNs, who may automatically assume that a personal development plan is personal to them, and their career development. They may have perceived that by completing their plan and showing it to their manager, this would result in the offer of support. However, the wording used is suspect, as it does not promise that the individual's learning and development needs will be taken forward. None of research literature reviewed explored whether and how RNs used these Personal DPs.

Interpretation of what a personal DP means could be left open, as the manager (under the direction of the employer) may or may not decide to act on the individual's perceptions of what they think they need to undertake to develop themselves and their careers. SA's Employee Performance Management Development System (Public Service and Administration Department, 2007, p13) has also placed a different perspective on when, why and how a Personal DP could be used: the *'purpose of the development plan is to identify any performance output shortfall in the work of the employee'.* Stating that the training and outcomes must be agreed by both the manager and the employee. Hence, this plan could be used as evidence to support development, but on the other hand, it could be used evidence to discipline RNs who are not performing at the standard stated in their job role. It is questionable to how much or what types of support is given, and what development support to personal support is given.

Employer's mechanisms of supporting CPD for RNs can be used in many different ways. It could be used as a way to control and police employees

and place sanctions on them by the employer and/or the professional regulatory nursing body. Rego and Cunha, (2009 p334) allege that when CPD is used in this way, it can *"act as an additional source of stress, discomfort, fatigue, and low wellbeing".* Being told to undertake a development activity with no choice to decline, be it core training (mandatory or in-service) or an academic course, could have a negative impact on women RNs' perceptions and experiences of PPD.

It is argued that Personal DPs that are not created by or with the employer could take a different format and approach. Personal DPs written by the individual RN for only themselves to action are recommended, as they are argued to lead to career development and safe and effective practice. The actions of assessing and evaluating competence, expertise and academic qualifications aids the RN's PPD (Fleet *et al.*, 2008; ICN, 2001, 2006, 2007, 2009a, 2009b; WHO, 2011; WHO, 2016a). Both the pay framework and the personal development plan are intended to feed into the appraisal process whereby development needs can be identified and aims need to be negotiated (RCN, 2017e). Yet a gap in knowledge is that no evidence can be found to state what experiences. RNs have had when negotiating with line managers to undertake PPD activities. This study aims to explore this further.

2.2.16 Bonus payment and bonus systems that encourage engagement of PPD activities

Some private employers in SA and the UK operate bonus pay schemes. Details on how a staff member achieves bonus pay were not available on the internet, though it was indicated that bonuses could be paid as a reward for achieving PPD. However, the system remains behind closed doors. It is assumed that the exact details of the criteria and evidence of activities are communicated to employees.

There is no bonus system offered to UK RNs working for the NHS. The yearly bonus scheme, otherwise known as "getting the brown envelope", was

introduced into the SA NHS with the purpose of aiding recruitment and retention, and to encourage staff to engage in PPD activities and to compete against the private healthcare sector (Fouché, 2007b; South African Information, 2007b). There was no evidence published on the internet on the guidance for NHS staff; the system appears to be managed by line managers and the organisation's management team. On reflection, I had learnt during my time in SA that RNs are asked to provide written evidence that can consist of examples of the knowledge and skills that they have gained over the past year, and to provide reflections on their experience and when they implemented their knowledge and skills into their practice, along with any PPD activities they have undertaken, such as qualifications. The literature review found no evidence to confirm how this was perceived or experienced by RNs undertaking PPD activities. Leaving it debatable to how effective the bonus system is in encouraging CPD for all RNs to access.

2.2.17 Nursing Career Frameworks

Frameworks have been written by governments, the NHS and nursing bodies to demonstrate career progression and to guide the RN as to what academic qualifications are needed for the differing levels of specialist roles that nurses are now undertaking (Modernising Nursing Careers, 2012; ICN, 2009b; NHS Scotland, 2018b; SANC, 2018a). These describe what the RN needs to have in terms of qualifications, and sometimes experience, to progress within their chosen speciality and these are aligned to the country's national qualifications framework. These frameworks acknowledge that RNs' roles may require educational qualifications, from a higher certificate in education (SA), to masters and PhD. Hence, they offer the RN insight into what qualifications they need and would be expected to have for a chosen speciality. The criticism is that these frameworks are descriptive, and are limited in guiding RNs on how to progress in their journey of PPD (Rafferty *et al.* 2015). No literature was identified that offered further guidance on these frameworks hence there is a gap in knowledge with regards to the detail

needed to understand to how the RN progresses in their journey. However, the positives are these aim to offer RNs guidance on what PPD activities are needed, so that they can plan their careers, having knowledge of the qualifications required for their aspired job roles.

Munroe (2008) concurs that employers can offer little support in developing RN and argued that continuing development of the RN was resulting in a charity paradigm (see Figure 4 below). Yet, through the development of their knowledge and skills, the RN personally contributes towards their employing organisation. Employers may offer to provide training courses within the organisation that accommodate service needs, but these are not necessarily the courses that will support the individual's career development. Munroe states that *'over reliance on the personal motivation, goodwill and personal financial circumstances of individuals perpetuates the charity paradigm and effectively undermines the worth of the individual in the organisation'* (Munroe, 2008, p959). Gould e*t al.* (2007) supports Munroe's assertions finding in their study that RNs complained that managers expected RNs to *'invest personal time in CPD intended primarily to improve service delivery, that this resulted in considerable resentment'*, (Gould *at al.* 2007, p603). Brekelmans *et al.* (2016) found that it depended how important the RN perceived the activity to be, to decide if they would accept the conditions employers offered (such as time and costs) and how these could impact (positively or negatively on the activity) on to whether or not they decided to engage.

Beneficence	Maleficence
Staff Donations	**Employer Provisions**
Contribute own time, e.g. use days off or annual leave days to attend courses and to study	Give staff some time off to learn, but do not contribute to costs incurred
Pay own fees and other study costs, e.g. own computer, internet access, purchase of textbooks	Limited financial support given, but do not give time off to learn
Pay for travel	Provide locally-based mandatory courses or in-house short courses

Table 1 The Charity Paradigm, Munroe (2008, p959)

Munroe (2008, p957) also points out that there can be a *'potential dichotomy of purpose'* between the individual doing good for themselves and their careers, and doing good for the patient, service and society. Employers expect RNs to continue to develop themselves, in order to uphold their professional role and responsibilities with the focus on development to benefit the patient, service and society, than on their RNs' professional career development, personal development or personal aspirations.

Brekelmans *et al.* (2013) agree that the cultural and structural components of the organisation can have an impact on PPD activities and that employers have a responsibility to motivate their employees and acknowledge the requirement for knowledge and skills to provide a standard of care.

Brekelmans *et al.* (2013) concluded that the conditions that RNs need to participate in development activities are divided into two: intangible and material conditions. Both intangible and material conditions are needed to motivate RNs to undertake development activities.

Intangible conditions included receiving careers guidance, annual appraisals, coaching, having a say on CPD activities, independence, clear career prospects, supervision, job role and position and support from their supervisor. Material conditions included expenses for courses being fully re-reimbursed, being given access to engage on training courses and being provided with the time to undertake the activity.

It may be that, due to a different regulatory nursing system, Brekelmans *et al.* (2013) did not consider the external motivating factors, such as having to have evidence of development activities for re-registration or to demonstrate competency in the role. However, these findings clarify what RNs perceive as employer support, and to how they make decisions whether to engage or to not engage.

In summary it seems that that there are two different approaches towards the RN's Personal Development Plans (DP). Firstly, the NHS can support the development of RNs; yet, these employers may argue that learning and development needs are not directly linked to the job role to justify non-commitment towards RNs' Personal DPs (Rafferty *et al.,* 2015). The NHS appraisal and Personal DP can also be used as a mechanism for identifying and managing poor performance, causing conflicting understandings of what personal development is.

The second approach towards Personal DP includes action plans that are aimed at developing RNs career and goals that are more personal to the individual, for example studying for a Master's degree. Rafferty *et al.* (2015) argue that this much broader approach is essential to support recruitment and retention of RNs. In these plans, the individual has personal responsibility to put their plans into action (addressing any challenges), and not the employer. It could be suggested that what the individual perceives and understands Personal Development Plan to be, and what they may have experienced it to be, may have an effect their own definition of what PPD is.

This brings us to summarise that the concept of PPD has been shaped differently over time by employers, the government, professional bodies, regulatory bodies and the individual (Wallace, 1990) all of which may have an effect on RNs experiences and perceptions of PPD.

2.2.18 Challenges of undertaking PPD

This section outlines more of the barriers that WRNs are known to face that impact on their PPD. Revealing some of the issues that are so unique to women's socioeconomic status and the roles and responsibilities that they hold within the family and society.

The majority of RNs are women and so, many women may have family and home responsibilities that are frequently cited as having an impact on PPD activities. Beatty's (2001) study on RNs living in rural areas of the USA found that not having the time to travel to taught sessions, not being able to afford the costs in petrol and not having the time to study outside of paid working hours were significant barriers. Beatty (2001) also revealed that non-supportive partners had an impact on those who wished to undertake PPD activities. However, this study did not expand any further to detail what this involved; therefore, it was unclear in what way and how big an impact it had on women nor were challenges faced by single women addressed.

Beatty's (2001) study reported their managers to be unsupportive, and this had an effect on their studies. Again, they did not go into depth to indicate to what these supportive behaviours were. Some WRNs were argued to have been disadvantaged further as they had not had the confidence, skills or training to engage further in education and training. Perry (1995) and Narayanasamy and Narayanasamy, (2007) concur arguing that some RNs have not been able to take a positive approach towards PPD due to the negative experiences that they have of PPD whilst working in healthcare.

In a study of RNs working in London, Gould *et al*. (2007) identified a number of barriers to PPD in relation to the workplace and the manager. Advertising of jobs for RNs often included the perks of having PPD opportunities yet.

Gould *et al.*'s (2007) revealed that some RNs argued this to be "lip service", in that it was used solely for recruitment resulting in RNs feeling resentful towards their employers. On the other hand it was suggested that rewarding staff by giving access to PPD was one of the most successful ways of retaining RNs and promoting staff morale. Gould and Allen (2009) found in their research that those who experienced fewer opportunities to access training had lower job satisfaction. Job satisfaction is argued to be linked with developmental activities. However as Gould *et al*. (2007) point out, research studies do not distinguish if this is mandatory or developmental CPD, in that developmental activities may support career development.

Managerial style has been found to impact the learning environment. In Gould *et al.*'s (2007) study RNs perceived "good managers" to be those that encouraged PPD and were fair to all staff when giving access to PPD courses. Thus, they acted as gatekeepers; either positively, by supporting RNs' development, or negatively, by presenting barriers that would prevent access to PPD opportunities.

Munroe (2008) argues that managers need to be aware of discriminating factors that may affect RNs' contribution towards PPD. This could range from individual choice, family demands and finances. A literature review carried out by Schweitzer and Krassa (2010) confirms that the most common deterrents for RNs' participation in continuing education were financial, childcare and home responsibilities, and being unable to get time off work due to inflexible work schedules, all of which can be particular issues for women and highlight that women's private and personal lives can impact their PPD.

Banning and Stafford's (2008) study on community nurses' CPD aimed to explore the perceptions and experiences of nurses' CPD. A hermeneutic phenomenological approach in unstructured interviews on ten community nurses who had a range between ten to thirty years' experience resulted in the identification of barriers to CPD, which were found to be demotivating, a threat towards nurses' PPD and resulted in low morale within the workplace. For those RNs who did undertake PPD, many had to resort to using their own personal resources to substitute for the lack of organisational resources.

Organisational and personal resources which were found to be interlinked. Staff shortages, financial constraints. Lack of support and time constraints in undertaking activities within paid working hours lead nurses to rely more on personal resources. However, Banning and Stafford's (2008) study was limited in its findings, as it did not suggest any other types of support that could have been offered to RNs but focused only on the barriers. This study aimed to explore this further.

Many RNs working in today's healthcare environment may experience low staff morale, short staffing, difficulty in recruiting for nursing vacancies, high workload and expectations to work outside paid contracted working hours (NMC, 2010; The Centre for Health Policy, 2014; The Kings Fund, 2015; WHO, 2016c). Those RNs working at the "sharp end" of nursing were found to have declining commitment towards CPD (Gould *et al*. 2009). The environment that the RN works in can influence participation in development activities (Brekelmans *et al.* 2016). Additionally, shift work can cause reduced motivation and tiredness, that takes time to recover from (Hughes, 2005).

With declining budgets for healthcare, some RNs have only ever experienced poor working environments, which struggle for basic resources such as medicine, equipment and staff (ICN, 2007; NMC, 2010; WHO, 2016a, 2016b,2016c); ; DENOSA, 2016a). In SA, resources vary, as provinces with

higher rural areas often have fewer resources and more poverty (Mqolozana, 2008). Hence, RNs in SA may be working in much poorer resourced conditions than those in the UK including both environmentally and staffing wise.

Despite proof of the dangers and the effects that short staffing has on patient care and mortality (Buchan and Calman, 2005; Wells, 2007; DENOSA, 2016b; RCN, 2016, 2017c) short staffing appears to have become commonplace in healthcare.[3]

Govranos and Newton's (2014) research in Australia revealed that the culture and attitudes in the workplace can affect nurses' perceptions of continuing education. They found that the demands of the workplace results in a 'culture of busyness', with nursing care and other tasks needing to be completed within a set time frame. Time to undertake educational activities was not always viewed by others as 'real work'. Hence, the culture of working conditions and attitudes towards RNs that do take time to undertake PPD may be a barrier to PPD.

Lee's (2011) study on CPD learning and impact upon positive practice change revealed that RNs experienced problems in the workplace when wishing to develop themselves and share their knowledge and encourage colleagues to develop practice. When trying to introduce changes into practice, they perceived obstruction from their managers, and they feared being labelled as a troublemaker. Though they did not elaborate on what they perceived the reasons to be for this. Whereas Gould *et al*. (2007) findings took a step further and revealed that some participants suggested managers prevented them from undertaking PPD because their they saw it

[3] The Welsh government introduced the Nursing Staffing Levels Act in 2016 whereby employers are expected to make reasonable decisions on staffing levels. The effectiveness of this is unknown (Welsh Government, 2016).

as a threat, being that a member of staff would have superior knowledge to them as manager. Furthermore Lee (2011) argued that RNs experienced a clash of cultures between the PPD that they had undertaken, and an organisational culture that prevented application of change that would promote better practice. Hughes' (2005, p47) research described *"the path of frustration"* experienced by RNs who had undertaken a development activity and had new ideas, and the motivation to change practice. However their attempts to change practice were unsuccessful, having faced resistance and a shortage of resources. Hughes (2005) concluded that working in this climate resulted in frustration, apathy, disillusionment and disempowerment. The manager's leadership style also impacted upon this working environment, in that those managers who were enthusiastic were also affected by the lack of resources needed to implement change and conversely, struggled with team members who saw no need to change.

Lee's (2011) findings highlight that those RNs who spoke of having experienced supportive colleagues acknowledged that it was mainly their own personal self-motivation, drive and leadership skills that allowed them to use their PPD to improve practice (Banning and Stafford, 2008). Hence, these perceptions and experiences of using the knowledge and skills gained from having undertaken PPD activities were down to the individual self, as well as the support that they received from others.

Hughes (2005) findings reveal what they termed as nurses' negativity towards CPD. Making an enlightening but obvious observation in that even though RNs valued professional development, this does not mean to say that they enjoy development activities. Some nurses were undertaking just enough developmental activities to accrue the minimum hours needed reach the PREP standards (NMC, 2011). Hughes notes some differences in barriers to PPD by RNs depending on their type of work. Some RNs were based in nursing homes (NH) and others in hospitals (H).

The most commonly cited negative reasons were lack of opportunity to implement new ideas (80% NH-100% H), other (40% NH - 50% H), lack of relevance (20% NH - 25% H), and not learnt anything new (4-5% NH - 20% H). Hughes (2005) suggests that 'lack of relevance' and 'not learnt anything new' may imply that nurses in this sample did not have the ability to undertake reflection or apply learning into practice, or that they experienced a lack of direction in professional development. Hughes failed to collect data to indicate what professional development activities these nurses were referring to. For example, if these were in reference to formal or informal PPD activities, or to acknowledge, for example, that it may have been down to the content and style of delivery of the study day that was managed by the training provider or if it was the conditions in which the PPD was to be undertaken. However, Hughes recognised that there may be a connection between the reasons for doing development activities and the perception that it creates. Though it is suggested by Hughes (2005, p46) that some of the activities undertaken are *'inappropriate for an individual nurse's developmental needs'*, presumably because nothing new is learnt, or it could be that it was too challenging for the individual. The method of using closed questions resulted in not exploring these negative perceptions in sufficient detail. The 'other' category ranged from 40-50% and were not discussed in detail, suggesting that there are more reasons that have not been explored to date in research on WRNs' PPD indicating a gap in the knowledge. These reasons could have told us more about RNs' perceptions and experiences of PPD that have an impact on PPD and on shaping of knowledge that creates an individual's perception of PPD. It is important that these are explored, in order to understand this concept further.

Gould *et al.* (2007) research expands on negative experiences their study, conducted across city areas of London, cited RNs who had language difficulties in that English was not their first language, and where essays were used to assess learning. These RNs had spent more time on writing

essays in comparison to others due to struggling with the academic requirements that had been set within their PPD activities. Hence the use of English in assessments can be a disadvantage to those who do not have English as their first language.

Lack of work and/personal time for PPD has been consistently cited as a barrier to PPD. Gould *et al,* (2007, p607) state that the '*the area singled out for the most frequent and bitter criticism was the amount of their own time which individuals felt they were expected to contribute towards CPD, especially completing assignments'.* Many RNs stated that they regularly had to work over their designated paid hours, and that had a knock-on effect on their personal time and private lives (RCN, 2017e) including less time for PPD. Many women have roles and caring responsibilities at home and with their families; these are priority for them (ICN, 2001). The commitment to undertake PPD in personal time and use personal finances is expected to be sacrificed by the nurse, outside of paid working hours has been shown to have an effect on nurses' home and family lives (Schweitzer and Krassa, 2010). Research has shown that women's commitment to home and family life has disadvantaged them, and, for some of them they have been unable to carry out PPD outside of paid working hours (Munroe, 2008). The RCN (2015b) report confirms that RNs have little or no time spare in paid working hours to undertake development activities. Munroe (2008) argued that lack of support in terms of financial support and support to study within paid working hours are viewed to inhibit the growth of nurses. Reports from nursing unions argue that employers are not supporting RNs' PPD within today's healthcare environment and, as a result, PPD activities are becoming more difficult to undertake within paid working hours, encroaching on women's personal private time (RCN, 2013; RCN, 2015; DENOSA, 2016).

Therefore, it is important that a detailed review is taken on these issues. For many RNs in both the UK and SA, core training is maybe the only type of PPD activity that they can access within paid working hours. For other RNs,

their experience is far worse, as they report that they have not been able to engage in core training (mandatory or in-service), due to being released from the work area, often blaming this on short staffing (RCN, 2012, 2017e).

As part of RNs' work contracts, both the **SA** and **UK** NHS expect their employees to keep their knowledge and skills up to date by providing core[4] training for all RNs. This training falls under the classification of CPD; the employer and the professional regulatory bodies stipulates the minimum requirement for CPD activity for all staff. These training days attract criticism being that the way in which the taught sessions are delivered means that not much is learnt from them (Govranos and Newton, 2014). The **SA** NHS currently offers no online learning, whereas in the **UK** online training sessions are much more commonly used[5]. Chipchase *et al.* (2012) discussion paper argued that though some may prefer the traditional taught mandatory courses, CPD being delivered via online sessions could offer collaboration with others and has its advantages, such as suggesting that staff could undertake their core training activities during 'found time' within their working day. However, it is questionable if this is achievable within the working day.

Studies have revealed that work location and shift pattern can have an impact on access to PPD activities. Those close to retirement, working weekends, working night shift and undertaking part-time work appear to have less access. Managers also spoke of not being able to leave the work area to undertake PPD activities, as they were expected to be on the ward (Gould *et al*. 2007). Hughes' (2005) research findings suggested that RNs working in

[4] In SA, they call these training days 'in-service' training days. In the UK they call them 'mandatory' training days. Hence, I have termed this as 'core training' to avoid confusion.

[5] These trainings can be delivered in the format of taught sessions, with staff travelling to a set location to attend the training session, or online, whereby the individual staff member completes online activities that often involves a test at the end with a score to pass or fail.

the private sector experienced more difficulty in accessing professional development because of lack of availability to be able to be released for PPD activities and the reliance that they would be available to work as many hours that was needed. However there was no SA research to suggest that they had the same experience.

The literature search did not reveal the processes in which RNs can apply for financial support. This may be because these are managed within the employer domain and if there are policies and procedures, they are not published on the internet. Hence, I have provided further information that I have learnt about these systems within the background information situated in Appendix D. This study aimed to explore this further.

Governmental plans for NHS service delivery and future service needs are very briefly outlined on the NHS website and the NHS five year forward review (NHS, 2014, 2018) and placed in more detail in each employers' policies, financials and workforce planning documents. However, these are only accessible to staff (though it cannot be assumed that staff have access to all information with regards to budget allocation from higher level to decisions made to allocate funding for individual staff/grades/professions).

The RCN (2017a) argued that *'with services under pressure, tighter budgets and a struggle for resources, nurses often report feeling neglected or stunted when it comes to their professional development'.* This comment is made with reference to the amount of monies left in the education and training budgets, after employers have placed priority on allocating monies for core (mandatory or in-service) training. There is little left to fund other PPD activities, namely formal PPD that requires costly university or college fees that RNs have identified as crucial for their development. **SA** union websites do not have an equivalent to the RCN, so no reports of the same standard could be found or used to compare between the two countries.

The system of allocating monies for PPD activities for the RN appears to be straightforward and managed in a transparent and democratic style. However, this changes when the money is divulged to the individual employing organisations with every employer operating their own processes on how they allocate monies to support RNs' PPD it is debatable how these processes work or what RNs' perceptions and experiences were with regards to gaining support, as no literature was found detailing this. The RCN (2017) makes it clear that RNs feel they are not being fully supported and are struggling to gain access to support from their employers. This could also indicate that RNs are not satisfied with the processes for allocating monies for PPD.

Additional funding for PPD activities is available through nursing unions and professional organisations, charities, donor funding, private sources, academic and research institutions in the form of scholarships, bursaries and awards. It was noticeable that when researching the internet, there was a range of funding opportunities to apply for bursaries for pre-nurse training, but much less for qualified RNs. Even more revealing was that the **UK** had a number of funding opportunities advertised for RNs via websites (my own research found a maximum of 20), but this was a far lower number in comparison to opportunities for medical staff). In **SA** only one website could be found was through the DENOSA. On exploring **SA and UK** university websites it was discovered that some universities offered applications for needs-based bursaries for postgraduate students (The University of Cape Town, 2016; Cape Town, 2018; Gov.UK, 2018; Nurses.info, 2018; The University of Stellenbosch, 2018). However many RNs from both **SA and the UK** who plan to work and study would earn more money than the stipulated maximum level so that they would be unable to apply (The University of Stellenbosch, 2018). Hence, many of these sources of funding would be out of RNs' reach.

It seems then that the chances of RNs obtaining funding for PPD in the **UK** are low and even lower in **SA**. Two potential explanations are proposed for this. Firstly, that there is a large number of RNs employed – this could reduce the chance of being successful if only a small amount of monies had been allocated. Secondly, that there are very few funding opportunities being advertised that can be accessed by RNs and some funding opportunities have very specific criteria. Very few funding streams offer generic funding for RNs wishing to undertake PPD activities.[6]

It needs to be noted that on completing the collection of data for this study, the **UK** government introduced a loan system for students planning to study an award of a higher level than previously studied (Student Finance England, 2016; Gov.UK, 2018). However, the criteria for applications could only be made for a loan to pay for a whole programme of study, e.g. a Masters, MPhil or PhD. It could be argued that these criteria discriminate against many RNs who may wish to study individual modules or courses and other who may have already gained academic credits in some modules and wish to add others to complete a programme[7].

In addition, in the **UK** some women may have debt from their initial re-registration undergraduate programmes as they begin their careers as RNs[8].

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[6] On a personal note, to obtain funding for this study, it only met the criteria for one charity. If I had not undertaken a comparative study between two countries I would not have been able to gain funding, as my study was on RNs and not focused on nursing/a condition or disease.

[7] It needs to be noted that from 2016 and 2018 the UK government offered loans for postgraduate degrees (Student Finance England 2016; Gov.UK 2018). The criticism of the master's degree loan is that it only funded the whole course. Hence, RNs who have accumulated level 7 academic credit from previous studies could not access this loan (Student Finance England 2016).

[8] Some RNs are successful in obtaining funding through government grants and bursaries (some of which are means tested), whereas others have had to take out student loans via the government, bank and loan sharks, and, in addition, have to ask for financial help and other means of support from friends and family to be able to complete their studies (NUS, 2015, 2016; Department of Women, 2015).

The literature search did not reveal any studies that focused specifically on RNs and the debt occurred from undergraduate study and how this may have influenced their future PPD. It did reveal that many RNs struggle with the pay that they receive, for pay is too low and that this could have an effect on their PPD, should they wish to undertake formal study (ICN, 1999; RCN, 2017b).

Many women who work as RNs, may not be successful in gaining financial support for PPD and will have to resort to self-funding[9]. On reflection, issues such as poverty and/or no monies left at the end of the month due to having paid outgoing costs for the family and other household bills may influence women's decisions to undertake formal PPD. However, no literature was found detailing the decision-making and commitments made to finance PPD this study aimed to research this further.

2.3 Summary of the literature review

The literature review was divided into four sections. The first two sections focused on PPD, its origins and meanings, and engaging and recording PPD. The next two sections focused on employers and PPD and the challenges of undertaking PPD.

It was identified that PPD improves RNs knowledge and skills (Gilbels *et al*., 2010). The concept of PPD and its associated terms has many complexities. There are many different elements and factors that link both directly and indirectly to PPD (Hughes, 2004, Narayanasamy and Narayanasamy, 2007; Schweitzer and Krassa, 2010). CPD and LLL have both played a part in the

[9] It is recognised that RNs who decide to undertake further formal studies, if they are not given financial support from their employer (this may have involved a contract of agreement that the employee has to work for a stipulated number of years or re-fund the monies), may have to seek funding from other sources, such as scholarships, grants and bursaries. To apply for bursaries in SA, these are often means tested; an RN's wage is mostly likely to render them as earning enough monies above the minimum for means testing (The University of Cape Town, 2016; Johnston, 2017; nurses.info, 2018; Royal College of Nursing, 2018b; The University of Stellenbosch, 2018).

evolving term PPD. Along with the systems and processes used by employers: appraisals, portfolios, pay frameworks, personal development plans and nursing career frameworks that are mainly focused on professional development. The literature review did not find a universal definition of PPD but did support the working definition that PPD was both personal and professional. The findings of this review was that it did not truly acknowledge the impact of these complexities on RNs PPD that could flex PPD as being more professional then personal or vice versa. Hence the study aimed to explore how women RNs experience and perceive PPD in order to further define PPD. And to explore to how the dynamics of the personal and professional flex between each other.

Whilst healthcare employers' training and education policies give the impression that they provide opportunities for employees to undertake PPD activities. Hence, they claim to support and aid RNs' PPD. Yet, in reality, nursing unions/colleges and some scholarly papers argue that this not the case (Gould *et al.* 2007). The UK's RCN (2014) argues that as the learning provision within the workplace is been scaled down, RNs may no longer have access to 'protected learning'. This refers to both formal and informal PPD activities. The RCN (2017e, p7) reports that *'employers often have study leave policies, but that all study leave may be cancelled due to winter pressures, staff shortages, increased patient loads and staff sickness'.* Confirming RNs are having difficulty in accessing PPD within paid work time because of workplace pressures.

It is important for the success of PPD in nursing that we have a working knowledge of what nurses' experiences are in relation to PPD; how this experience has had an effect on their perception of PPD and what they think or have experienced that could improve RNs' PPD. This review established the importance of PPD for RNs, as they have to have evidence of PPD activities to support continuing professional registration and to demonstrate competency in their job roles that are aligned with pay frameworks and it acts

as an aid to employability and career development. Additionally, employers need RNs to engage in PPD in order to promote safe practice, achieve patient outcomes and deliver healthcare standards (Rafferty *et al*., 2015). Studies suggest that there are professional, personal and work related motivations that have an impact on WRNs perceptions and experiences (Brekelmans *et al*. 2013; Pool *et al.* 2014; Brekelmans *et al.* 2015; Berings *et al*. 2016).

Women RNs' experience of support for PPD from the employer can vary. On one end of the scale, RNs' positive experience is that they are released from the workplace to undertake PPD activities, and that formal PPD activities that involve academic study are paid by the employer. Hence, employers are viewed to be supportive towards RNs' PPD. Yet, at the other end of the scale, RNs' negative experience is that they had received little or no support from employers to undertake PPD activities, resulting in them having to undertake PPD in their own personal time and, depending on the activity, they may well have to decide if they need to self-fund their studies in order to progress in their careers. For many WRNs time and finances was their biggest challenge (Hughes, 2005; Drey and Berridges, 2007).

Strategies and techniques used by RNs that could aid the success of PPD were missing from the literature which is a real concern for without knowledge of these WRNs risk not being able engage because their challenges are too great.

This stepping over the line from PPD being carried out in paid working hours to it being carried out in the RN's personal time and private life has raised many questions, which had brought me to recognise that I needed to explore RNs' concept of PPD. Is personal development and professional development perceived and experienced to be joined together, or is the professional development and personal development something that RNs perceive to be and experienced as separate, or interlinked at different

points? And if so why? And what are the rewards and benefits of doing PPD as the literature appears to focus more so on the professional aspects and very little on the personal. Both of these points would have to be key questions within the study, as this was needed to make sense of RNs' perceptions and experience of PPD in today's healthcare environment. An aim of this study was to research more in depth on the personal aspects of PPD.

It is evident that, despite the positive literature that supports the concept of PPD, many nurses are facing difficulties in negotiating support and undertaking PPD (Gould *et al*. 2007; Munroe, 2008). Organisational policies have designed strategies and frameworks to be implemented in practice that claim to support and aid RNs in PPD. Yet, in reality, nurses' perceptions and experiences were not found to be supportive (Beatty, 2001, Hughes, 2005; Gould *et al*. 2007). The RCN (2017) states that many RNs do not perceive nor experience PPD in a positive light, and that there has been little reward for their efforts, particularly in this current economic climate. It appears that when healthcare organisations' or employers' budgets and staffing levels are low this threatens the success of RNs' PPD being supported within the organisation and has led to a reduction in support shifting the responsibility of PPD more onto the RN and less on employers.

Employer's time (within paid working hours), resources, and monies, used in the past to support RNs' PPD activities, are being gradually eroded. Yet, these same employers expect and place requirements on RNs to engage and record their PPD activities, some of which are essential for their current job roles as well as for their future career development. UK and SA nursing unions/colleges argue that employer support for PPD varies from one employer to another and, in addition to this, RNs are found to struggle to gain access to PPD activities for a number of reasons, including short staffing and demands of the workplace being placed as a higher priority than releasing

staff from the workplace to engage in PPD activities (RCN, 2013; 2014; DENOSA 2016a, 2017).

Hence, reports by unions/professional groups such as the RCN (2017) indicate that PPD activities are not being achieved and many RNs are holding negative feelings about the concept of PPD, having experienced the reality of the difficulties faced when trying to engage in PPD activities. Many women have to undertake PPD activities to keep current and up to date in their practice, regardless of whether it is in their professional paid working hours or their private personal time. But as the theories of mechanisms such as a portfolio, personal development plan, and frameworks to support PPD are plausible, there is little evidence to say that RNS have the support to undertake these PPD activities within their paid work time many of which the RN would argue are professional development activities. Activities that are aimed to help RNs set their personal aims and goals may be regarded as personal goals and not supported by the employer. The other criticism of these is that it is often the personal responsibility of the individual to put their plans into action, which makes the professional development shift towards personal development. Hence there is a weakness of the literature that doesn't explore the dynamics in enough depth. Without knowledge of the range of difficulties women experience and on the successful strategies and techniques that they have used, WRNs may struggle to put their plans into action, hence not be able to engage in PPD.

Hence, it was important for this research to examine women's experiences and perceptions of PPD, as this knowledge will generate knowledge which could help women RNs could be more successful in PPD activities. This could lead to influencing future budgets for education and training, and policies and procedures that will be more effective in managing and supporting RNs' PPD for RNs in both SA and the UK. It could also influence RNs worldwide.

Chapter 3: **Methodology**

This chapter discusses my own standpoints and how this influenced the methodology and design of this study. A feminist approach influenced this this study. The process of collecting the research data and using constructivist grounded theory (CGT) reflexivity and constant comparison, to analyse and code the data are then discussed. The process of this study, consisting of recruiting WRNs from universities in SA and the UK who were from a range of backgrounds and a representative sample, is then presented. Ethics permissions for the study were obtained (see Appendix E). Recruitment of participants was achieved through recruitment leaflets (Appendix F), emails and talking to WRNs about the study. Potential participants were given information on the study (Participant Information Sheet (PIS) Appendix G). Interviews consisted of participants completing a short answer questionnaire that acted as a demographic data sheet (DDS) (see Appendix H) followed by the interview which was guided by semi-structured questions (Appendix I). In the analysis, interview transcripts were read and re-read, and data was analysed using a CGT approach and constant comparison was undertaken during the conduct of the study alongside the data collection. Findings were used to guide the sampling and data collection. Reflexivity was central to this along with a feminist approach to analyse the data, identify and test the categories and relationships between them and develop the findings (Creswell, 2014b).

3.1 Designing the title of the research

Savin-Baden and Howell Major (2013) establish that the title of the research study needs to be framed through the philosophical and personal lenses of the researcher, as this supports the reasons why the researcher wishes to research this subject in further depth. The theoretical framework aims to set the foundations of the research study. Merriam (1998), cited in Savin-Baden and Howell Major (2013), proposes that this can be used to view and frame their research. The philosophy and theory lens starts with viewing the

researcher's worldwide view (paradigm), the framework, phenomenon, approach, data collection, data analysis and data. This study has been designed by myself who wished to research women's experiences and perceptions of PPD using CGT and a feminist approach. With this in mind, women were placed central to this research; hence, "women" were placed into the research question, supporting Delamont's views that placing gender within the title increases clarity by *"sharpening the research question"* (Delamont 2003, p63).

3.1.1 Ontology and epistemology

Grey (2018, p21) states that ontology is *'the study of being' and 'the nature of existence and what constitutes reality'*. Guba (1990, p27) expands by stating that realities exist in a *'form of multiple mental constructions, socially and experientially based, local and specific, dependent for their form and content on the persons who hold them'*. (Grey, 2018, p21) argues that for relativists *'there are multiple realities and ways of accessing them'*. Therefore relativist ontology supports the decision to explore WRNs perceptions and experiences of PPD using CGT of which data informs the researcher of the realities of individuals lives and a feminist approach that challenges and questions where has knowledge come from, and to if these forms represent women's voices and the realities of their daily lives (Flick, 2018; Hughes, 2002). It is argued that ontology and epistemology cannot exist without each other for as Flick (2018, p21) points out *'ontology embodies understanding "what is", epistemology tries to understand "what it means to know"'.* Hughes (2002) asserts we need to understand the relationships between them, Grey agrees for epistemology *'provides a philosophical background for deciding what kinds of knowledge are legitimate and adequate'* (2018, p21). For this study the epistemological stance is constructivism. Grey (2018, p22) states that truth and meaning is created by the individual's *'interactions with the world'* that individuals *'construct their own meaning in different ways, even in relation to the same phenomenon'.* That *'multiple, contradictory but equally*

valid accounts of the world can exist', hence this supports this study in which I wanted to explore SA and UK WRNs perceptions and experiences of PPD.

3.2 Undertaking comparative research between the two countries

The International Council of Nurses (ICN, 2015a) states that difficulties with regard to the development of nurses is happening worldwide often due to *"workforce shortages, ageing workforce, underemployment and unemployment, skill-mix imbalances and geographical maldistribution".* Yet, the initial literature review did not reveal any comparative research studies between two or more countries that identified and focused specifically around the effects on WRNs' PPD or how WRNs have been overcoming these difficulties (ICN, 2007).

For the research to have the most impact it was decided that focusing on only one country and its issues would not provide research outcomes that could be easily applied to other countries (Ember and Ember, 2009). The idea of conducting a comparative study is to examine and compare two countries on their WRNs' perceptions so that understanding, and experiences would be of far more benefit. The results of the research would advance knowledge, by painting a bigger picture of RNs and PPD that could have a much higher transferability whilst also highlighting the cultural and organisational differences and to how these impact on women's PPD (Ember and Ember, 2009).

The research was about and for women, and aimed to gain rich data and findings which will be of benefit to women; some aspects of the findings that are not gender-based may also be of benefit to male RNs. Bryman (2016) stresses that comparative research can be applied to a variety of situations rather than a comparison based solely on two nations. Taking this into account, I wanted the research findings to be of potential benefit to women worldwide, and to have an impact on global thinking on RNs' PPD. The

advantages of carrying out comparative research was that the concepts, perceptions, experiences and practice of PPD could be compared between two very different countries, presenting new knowledge about PPD for women RNs and highlighting where key common issues prevailed in particular in relation to gender. Bryman (2016) argues that comparative research holds a stronger position in identifying emerging theories. For using a findings from two countries can be used to give contrast and highlight textual issues. Ilesanmi (2009) posits that comparison can lead to the researcher being able to identify more clearly the nature or shapes of the relationships of the data. Ember and Ember (2009) state that the advantage of studies that compare against other countries is that it can demonstrate the commonalities and differences between them, is more likely to be closer to the truth, and could be used as an example of worldwide comparison.

For these reasons, a comparison between two countries was considered to be an important cornerstone in the research design, and because of this, the culture also needs to be taken into consideration. Mincov (2013) stipulates that the researcher needs to clarify their understanding and use of the word 'culture' to avoid confusion. Culture has many different definitions; for this research study, culture is based on human culture and not biological cultivation. Mincov (2013, p17) makes the key point that culture is a construct and "*that constructs are not reality itself but imaginary models that we build in order to organise it in a way that makes sense to us and, we hope, to other people*". The Oxford Online Dictionary provides definitions such as *"the ideas, customs and social behaviour of a particular people or society"*; another is *"the attitudes and behaviour characteristics of a particular social group"* (Oxforddictionaries.com 2017). Whereas Browaeys and Price (2015) define culture as having concepts, visions, norms and values, behaviour and a product of what it represents.

For this study, that is questioning the perceptions and experiences of women RNs, Browaeys and Price's (2015) definition has been referred to, as this

study wished to focus on what personal and professional development meant to women; what it represents, the concepts, visions, norms and values.

Mincov (2013) also reminds us of Hofstede's (2001) Onion metaphor, which supports the notion of culture having many layers. The visible layers are the outside layers that can be seen, observed and compared. The invisible layers are the ones that are on the inside – the layers that people are not fully aware of, that are based on the individual's "mental software". This study aimed to collect and analyse data that was mainly the outside layer of culture, but also to collect the inside layers, in relation to women as individuals.

3.3 My feminist approach towards this research

Through my own personal experience of working with women RNs, I had become aware of women talking about the difficulties they had been experiencing with regard to their PPD, both inside and outside of paid work time. It brought me to recognise that there were many differences between women RNs and how they viewed the concept of PPD and their own PPD. That women's lives outside of work were equally or more important to them, that some could not sacrifice using their personal time to undertake PPD activities, while others had responsibilities in the home that could not be ignored (Fox, 2015). Therefore, a feminist approach was used for this research, as women are central to this research (Scholz, 2010) which will be discussed later on in this chapter (see section 3.9).

3.4 Selecting the research design to meet the research aims: qualitative versus quantitative

Quantitative research was not considered to be appropriate for this research design. Because quantitative research focuses primarily on numbers and statistics rather than words, it can keep the researcher at a distance, whereas the research study aimed to work closely with participants to collect rich deep data that would help the researcher gain an understanding of the

meanings and concepts that are often associated with qualitative research (Bryman, 2016; Porter, 2000). Quantitative methods of collecting data through experiments, and reports that measure, were rejected in favour of using the qualitative approach, which aimed to explore the reality, experience and meanings behind participants' perceptions and experiences (Braun and Clarke, 2013). Bryman (2016, p401) asserts that *'quantitative researchers typically bring a set of concepts … leading to the theoretical work preceding the data collection'*. For this research design, it was planned to be inductive, so that exploration of women's perceptions or experiences would be used as a starting point to build upon an understanding of the multiple realities of women's perceptions and experiences of PPD. Interviews with women on an individual basis would allow space for women to express how they felt and what they had experienced.

Schrauf (2016) affirms that questions using words such as perceptions and experiences are *'the essence of qualitative work'*. Braun and Clarke (2013) argue that qualitative research is recognisable by its beliefs, values and assumptions and practices in that it withholds the view that there is no one truth, but instead there are multiple versions of reality that are situated within the context in which they have occurred. Qualitative researchers reject notions of objective unbiased research. They support the concept that the researcher brings their own subjectivity, as the individual researcher has their own understandings of cultural, social, gender, class and personal politics. Charmaz (2006, p132) argues CGT aims in its generation of theory to acknowledge the *'ever changing world but recognizes diverse local worlds and multiple realities … the complexities of particular worlds, views and actions'*. These all form their own framework of making sense of the world (Creswell, 2007; Braun and Clarke, 2013).

The literature review established that there was not enough pre-existing knowledge on women RNs' perceptions and experiences to justify the use of

standardised data collection methods used in quantitative research such as a survey, which would have aimed to test a hypothesis or to document prevalence (Bowling, 2009). This research was designed to gain insight into the "bigger picture"; this could be achieved by having a range of women RNs from different backgrounds participating in the study, who held a wealth of different experiences and perceptions. The only way to achieve this aim was through qualitative research, using a feminist approach. The idea of using mixed methods was rejected. The research incorporated having have a short questionnaire that acted as a demographic data sheet (DDS), which demonstrated the characteristics of participants involved in the research (see Appendix H for this short answer questionnaire). It was not designed to house any quantitative purposes, such as comparing or analysing the differences within or variation within the group (Schrauf, 2016).

3.5 Qualitative research and the researcher

Bryman (2016) postulates that the construction of knowledge is influenced through the researcher's own stance; that the researcher also needs to acknowledge how this has influenced their research, and the research process and how this may have impacted on their own interpretation (Savin-Baden and Howell Major, 2013).

It is recommended for this type of research design that the researcher makes themselves visible by presenting themselves as "I". This demonstrates my involvement within this research (Bryant and Charmaz, 2011; Charmaz, 2013). Sprague (2016) argues this also demonstrates the author acts as an additional "resource in the research". Hence, in response to this, in this section I have included my own standpoint, which has influenced my design and approach (discussed later in this chapter: p111).

Qualitative research can be undertaken using many different designs, such as phenomenological interpretive analysis (IPA), and auto-ethnography; these are all suitable for small-scale research. Schraf (2016) asserts that

these are common choices for qualitative comparative research, as they are structured to capture participants' lived experiences and the culture that they live in. However, it was decided these were not suitable for this research as the study aimed to capture and represent a wide range of voices, hence the number of participants would be beyond the number of classed as small-scale research. The element of storytelling in narrative based research design may have been suitable for a study on one small group of people, with the focus of life histories on the issue being explored. It was deemed as unsuitable for this PhD study as I aimed to have more than one group and with the differences between the two countries that I wanted to study it was considered that I would not achieve the aims of the research (Flick, 2018b; Gray, 2018).

Out of these three different designs auto-ethnography was considered to be more appropriate as it is an effective research method as it encourages reflection on the self and what matters to the researcher (Ember and Ember, 2009). Of which I had felt was important because of my own experience of PPD and my connections with the UK and SA. However on further examination and reflection an auto-ethnographic approach was rejected as it would have resulted in more focus being placed on myself, the researcher, and would have failed to address less of the main aims of this study which again was to hear a wide range of women's voices (Wolf 2012).

To undertake a comparison of RNs' experiences and perception of PPD. The use of auto-ethnography would have led to reducing the numbers of participants, whereas this study aimed to recruit a range of women from differing nursing and cultural backgrounds, that were representative of women RNs. This research had a larger number of participants than originally anticipated in order to undertake theoretical sampling to achieve trustworthy results and to ensure that enough data had been collected to fully develop the identified categories required for this comparative research (Crang and Cook, 2007; O'Reilly and Kiyimba, 2015).

The "auto" would have involved myself revealing personal information that would have been made available in the thesis, being aware that this would be stored electronically in the university library (The University of Edinburgh, 2016c). I became more uncomfortable about this aspect of self-disclosure and wished to maintain some of my privacy, and have less focus on myself; for example, my journey of "returning back home to SA, my place of birth". However I was aware that by undertaking a CGT and feminist approach, "the self" would be expected to be presented when discussing the positionality, standpoint and reflexivity.

This leads on to the identification of the author within the research. I felt that the wording "the author" was not the best way to describe and identify themselves within the research. For the wording "author" suggests that they have been the viewer and transcriber of the research, which, Webb (1992) argues, is a form of deception. Within the research study I have played an integral role, as through reflexivity I have had an influence on the design, I have worked with the participants and been aware of my own influences on the analysis and findings of the research. Therefore, it brought me to conclude that it is appropriate for me to use the first person within this CGT study and situates the self within the symbolic interactionist perspective.

3.6 Symbolic interactionism and constructivist grounded theory (CGT)

Symbolic interactionism gives a theoretical perspective and is described by Bryman (2016, p27) as when *"interaction takes place in such a way that the individual is continually interpreting the symbolic meaning of his or her environment (which includes the actions of others)".* Snape et al. (2014 p14), cited in Richie et al. (2014), agree in that people interpret and find meanings and that this involves using *"their social actions and environments as a means of understanding human behaviour".* The researcher explores these environments and questions how this has influenced individuals' self-construction of their self-situation and society (Charmaz, 2014). The

interpretation and actions of practical activities that individuals undertake influence each other and results in symbolic meaning being created and developed.

Charmaz (2014) elaborates that symbolic interactionism gives the researcher a perspective that "opens up" ways of understanding. Snape *et al.* (2014 p14), cited in Richie *et al.* (2014), indicates that symbolic interactionism *"informed the development of grounded theory as a methodical approach"* and that grounded theory takes the next step by *"generating theories that explain social processes or actions through the analysis of data from participants who have experienced them".* Thus, this is an interpretivist approach which recognises that there is not one universal truth, but many different perspectives of the same world that we live in (Walliman, 2011). These subjected meanings of individuals' experiences lead us to understand that we live in a socially constructed world (Creswell, 2014b) and in this study, enables an understanding of the meanings and experiences that women have of PPD. For women this *'relates to their position in society as devalued, silenced or oppressed'* of which power and values play an important organising concept within research (Hughes, 2002, p155). Hence, the nature of my research recognises that there are competing world-views that can be used to frame research. The knowledge generated from this study may be regarded as provisional, for it cannot be quantified, as it is *'fluid and constructed by individuals in many different ways'* (Potter, 2017, p123). Hughes (2002, p155) argues that it is like a never ending spiral as the process of generating or building knowledge continues to turn and grow as new knowledge emerges. Flick (2018a, p466) argues that CGT affects epistemological issues, for it brings to question if we find or construct theories. Charmaz's (2006, p194) answer is that it encourages the development of CGT for *'interpretation of a studied phenomenon is in itself a construction'* and people *'construct the realities in which they participate'*.

Silverman (2011) suggests that the researcher needs to explore what the best data collection methods are in line with the research project being proposed in order to gather data that can be used to produce credible analysis. Bryman (2016, p691) describes grounded theory (GT) as *'an iterative approach to the analysis of qualitative data that aims to generate theory out of research data by achieving a close fit between the two'.* Sprague (2016, p156) postulates that in GT *'the goal of the analysis is to be as faithful to the data as possible'* making the point that meanings can arise out of actions, and, in turn, they can influence actions. Wuest (2012, p253) outlines that the *'grounded theory approach is most useful when the goal is from work or theory that explains human behaviour*. Ramazanoglu and Holland (2002) argue GT involves the systematic collection and analysis of the data, which then generates the production of theory, how this is undertaken varies according to the type of GT used. Bryant and Charmaz (2011, p292-3) reflected on the earlier grounded theories originated from Glaser and Strauss (1976) arguing that they tended to *'treat enquiry as separate from its social conditions'* and that *'they assumed that they remained neutral observers outside of inquiry'*. Classical GT focuses on questioning what is the emerging, rather than using an interview guide. It leads to a core category which must be the main central concept, and only once this has been developed can other concepts be developed from it (Rees and Glasper, 2016). Classical GT was dismissed for this study for Timonen (2018, p2) asserts Glaser and Strauss Classical GT *'is the strand most strongly underpinned by objectivism and closest to positive approaches' that these earlier approaches also appeared to focus on 'the drive to build theory not necessarily recording data'* of which was rejected for this study for these did not fit in with my approach. Strauss and Corbin's approach towards GT was also based on objectivist underpinnings therefore also dismissed for this study Timonen (2018). Charmaz (2006, p10) confirms that CGT is less linear in comparison to other GT approaches for CGT that can result in *'the best ideas may occur to us late in the process and may lure us back to the*

field to gain a deeper view'. CGT differs from other types of CGT for it *'does not adhere to positivist notions of variable analysis or of finding a single basic process or core category in the studied phenomenon'* that it *'places priority on the phenomena of study and sees both data and analysis as created from shared experiences and relationships with participants and other sources of data',* Charmaz (2006, p130-132). Bryant and Charmaz (2011, p292-3) add that CGT 'view research as occurring within specific social conditions' and wish to learn to how these conditions influence their research. That is the opposite to earlier grounded theorists' stance of being 'neutral observers outside of inquiry'. For CGT 'locate themselves inside inquiry to get as close to the studied phenomenon as possible' for they aim to focus on difference and variation.

Flick (2018, p7) asserts that theses early grounded theorists gave little or no attention towards 'epistemology or theories of knowledge' for "data is data", assuming *'that data and the relevant facts are already there'*. My decision to undertake CGT were based on Keane (2015) arguments in being CGT places the researcher within the context of their data and the wider study and that there are three key principles that CGT should adhere to. These are: firstly the researcher's standpoint, secondly building a participatory approach, including through theoretical sampling and thirdly through constitution and presentation of the CGT. Hence, it is argued that CGT is an ideal approach for this study in order to meet the overall aim and generate theory using a constructivist approach.

CGT establishes that the researcher must take account of their own and their participants' starting points and standpoints, as they can have an impact by shifting during inquiry, and reflecting on the conditions in the production of knowledge (Silverman, 2011). They are co-producers of the data, and immersion into this data will allow their participants' voices to be embedded in the findings and research outcomes (Savin-Baden and Howell Major, 2013). Braun and Clarke (2013) argue that GT is also an analytical method,

as it requires the researcher to undertake constant comparison of the data throughout the GT process. This study was therefore designed as a comparative study that involved several periods of data collection between the two countries whereby analysis was undertaken alongside and throughout the process of data collection as codes and themes were created.

Charmaz (2006) determines that the construction process of building on the realities of the research topic is essential. There are multiple social realities that need to be explored to gain understanding of the research topic's meanings. This supports feminist methodology in which it is indicated that much feminist knowledge has been created by the process of grounding experience (Ramazanoglu and Holland, 2002). Sprague (2016) points out that it aims to reject the preconceptions that may affect the data: by examining what the data says, this, in turn, creates and constructs the theory. Charmaz (2006, p131) argues *"constructivist see facts and values are linked … they attempt to become aware of their presuppositions and to grapple with how they affect the research".* CGT derives from the interpretive approach, which requires a flexibility to move and change during the process of data collection and data analysis, reflecting on the particular conditions of its production (Charmaz, 2006). This last point was especially important to this research design, for example CGT, fosters reflection and stresses importance on being alert to conditions and the situations that RNs currently found themselves in, when the research was being conducted (Charmaz 2006 and Silverman, 2011).

To conclude, CGT was selected for this research for its theoretical perspectives: as Bryant and Charmaz (2010, p610) express, it *"assumes that people construct themselves, society and reality through interactions".* CGT was an ideal approach for this study, as it aimed to understand how WRNs' constructed PPD through meanings and actions (Charmaz, 2014).

3.7 Methodology

Feminist research is often focused around theories of gender, power and gendered power (Ramazanoglu and Holland, 2002). By undertaking a CGT approach underpinned by a feminist standpoint in this research, it aimed to present research findings that capture women's experiences and perceptions of PPD, and what concerns women (Nielson, 1990). The feminist approach rejects traditional methodological approaches by challenging the "scientific" methods used that disadvantage women and other minority groups (Kralik and Loon Van, 2008). Feminist research challenges to what has been socially constructed revisiting womens knowledge that is based on experiences, concepts, norms and variables (Ramazanoglu and Holland, 2002). The feminist approach encourages women to participate in research that is for women, by women. Feminist research aims to capture what is happening to women to help them make sense of their own lives and identify social change and social justice for women (Kralik and Loon Van, 2008; O'Reilly and Kiyimba, 2015).

Ramazanoglu and Holland (2002, pp146-7) state that *"there is no universal definition of what is or is not feminist";* that the purpose of feminist research is to give gendered insights into gendered social existence that would otherwise not exist. Abbott and Wallace (1990) assert that gender is a social construction, and women's roles are not purely based on the biological aspect of a woman's body. There is agreement from all feminists that women experience oppression, subordination and oppose patriarchal ideologies that are often presented as universal knowledge (Pilcher and Whelehan, 2017).

Hence, feminists have challenged the "truths" around universal knowledge and asked the question as to where do women fit in with these "truths"? Ramazanoglu and Holland (2002, p147) argue that feminist research gives an insight into the *"gendered social existence that would otherwise not exist".* The theory around how and why knowledge has been constructed in this way has been challenged by the differing feminist perspectives: radical, liberal,

Marxist, socialist and feminism in the third world (Abbott and Wallace, 1990). The feminist socialist approach has been applied to this research design and will be addressed within this section.

O'Reilly and Kiyimba (2015) argue that there is some ambiguity around what a feminist approach is, questioning is it a methodology or epistemology, or both. Ramazanoglu and Holland answer this by stating that what distinguishes a feminist approach within methodology is that the researcher is positioned within the research, and that feminist epistemology is based on "the truths" related to power and knowledge that women have researched, often with reference to politics, ethics and morals (Ramazanoglu and Holland, 2002). Dawson (2015) agrees that there has always been some debate on this, concluding that the feminist approach incorporates both, methodology and epistemology.

Feminists have challenged the development of knowledge, arguing that much of our knowledge needs to be re-examined by women, and not by men. That there are many ways to construct knowledge. To produce valid knowledge, this needs to be re-written by women and that these women need to be representative of the many different backgrounds, for example age, race, class, disability and sexual orientation (Pilcher and Whelehan, 2017). Social constructionism supports the notion that the nature of constructing knowledge is undertaken when meaning and understanding is gained through the social settings, practice and experience. Savin-Baden and Howell Major (2013, p62) stipulate that this is *"when knowledge and the knower are interdependent and embedded within history, context, culture, language and experience".* Women know "what we know", as feminist knowledge is based on women's experiences directed through their own ethics and moral values (Ramazanoglu and Holland, 2002; Dawson, 2015).

3.8 Feminist sociological approach

Feminists argue there is a need to continue to develop knowledge that represents women's views and experiences, so feminist research can be of benefit to women (Abbott and Wallace, 1990). This research could have been based on both men and women; if it had been so, it could have ignored the difference between men and women, which, feminists argue, is missing from knowledge. Socialist feminists argue that male ideology has been viewed as universal knowledge, often distorting the truth, as ideology serves a purpose by supporting the interests of the group that has influenced the social construction of this ideology (Pilcher and Whelehan, 2017). The focus on difference is what makes the feminist approach unique in its approach. The position of power is often given according to the individuals or groups concept and understanding of difference. Concept and understanding of difference can be determined by a number of factors, such as the individual's beliefs, standpoints, experience, politics (Ali, 2000). The feminist socialist approach was selected, as it addresses the forms of oppression that women experience at all levels, from personal to organisational. It acknowledges the contribution of class, gender and racial subordination and supports the feminist theory of patriarchy and the control that men may have over women (Abbott and Wallace, 1990) making the links between power that is exerted from society and its social structure to the government, through the healthcare systems, the role of the RN, to the individual woman in the home. Abbot and Wallace (1990) highlight that, as well as the relationship between men and women, socialist feminism questions the relationships between women and the economic system, in which women's work is de-valued and often rewarded with less pay.

3.9 Reflexivity and positionality within research

Reflexivity is described by Finlay (2003) as *"a process of continuing reflexivity, before, during and after an event".* Bolton (2010, p12) describes reflexivity as *"a way to examine our thought processes by questioning our*

own understanding". Bryman (2016) argues that reflexivity has a number of sub-meanings, which can affect how it is used research. In this study, reflexivity has been used in two ways. Firstly, to undertake philosophical self-reflection and, secondly, as methodological self-consciousness, whereby the researcher takes into account their relationship with the participants of their study.

Creswell (2014a) argues that the researcher must be self-aware of how they position themselves in the research. That if they wish, they could also, as part of their reflexivity, reflect on some of their own emotional, intellectual, political thoughts and experiences. England (1994) agrees, proposing that the researcher has to be transparent in their own positionality, as conducting fieldwork is personal and reflexivity plays a central role within the research process, field and final text. Ramazanoglu and Holland (2002, p156) state that reflexivity is argued to be an integral part of feminist methodology, as it *"demands awareness of, and appropriate responses to, relationships between researchers and the researched".* I had felt that as a woman, and as an RN, and as someone who has engaged in PPD, I could not divorce my own experiences and I needed to acknowledge that I could be in danger of impressing my own subjective views onto the research (Letherby, 2003). I needed to be respectful of participants' views and acknowledge any bias that I or they may have (Creswell, 2007). As a woman researching other women, I needed to be visible within the research (Oakley, 1981) so that my own positionality was transparent. Again, this would show my own impact as a woman in the research study. This implies that power relations between the researcher and the participants were to be considered when carrying out the research and that reference needed to be made to the experience of unequal social relations within the recruitment, data collection and analysis stages, outlining any limitations and other effects that it may have had on the research process (Finlay, 2003).

Gough (2003) confirms that there is no set rule as to when reflexivity is used within research. In this research, reflexivity was used in the memo notes and research diary (that also recorded field notes) to reflect back, inwards, and to reflect on my own lived experiences. Raising self-awareness, being self-conscious about what the participants may have perceived and what distorted or hidden aspects may not have been explored, questioning what else may be there, but has not been revealed (Finlay, 2003). Reflexivity was used in the research diaries to act as a supportive and coping mechanism for myself in the research process and journey, and as I moved continuously within changing relationships with participants as an insider and outsider working between the two countries (Davidson, 2001). It was used to hold critical discussions with myself and my supervisors and when engaged in "target talking" with others to help answer questions raised during reflexive writing and to gain a greater understanding of the cultural differences and issues that were coming to light during the research. Conveying that, by living in a socially constructed world, it allowed myself to recognise that subjectivity within research needs to be treated not as a problem, but instead an opportunity to look differently at what we understand in our worlds (Finlay, 2003; Etherington, 2004). Reflexivity was used within the process of data analysis to interpret and understand, and to explore the "grey areas" in further depth (Gough, 2003) and to discover areas in which unique findings had emerged in this study.

This research is about WRNs, my design was CGT with a feminist approach and it was deemed to be the best choice for this research design (Delamont, 2003; Scholz, 2010). Edwards (1990) argues that feminist researchers are as much a part of the research process as the research itself. They need to recognise their own effect on the research, and how they have influenced, shaped and undertaken the research process.

I wanted women's voices to be heard in the research, which Bryman (2016, p35) asserts is a core value in feminist research, that focuses on the *"needs*

of women". Creswell (2014a, p179) points out that qualitative research *"seeks to hear all voices and perspectives"*, including the researcher's own voice, which is integral to the research though it is not a piece of feminist research it has used a feminist approach. Qualitative researchers have recognised that by using a quantitative objective scientific approach towards research, it may result in the silencing of participants' voices (Creswell, 2007). Whereas a qualitative researcher aims to avoid not hearing or misrepresenting voices, it is argued that reflexivity also has to be considered when carrying out qualitative research, though Roulston (2010) postulates that the unreflective researcher leaves themselves at risk of producing analysis on data that they naively think is valid. Whereas in truth, this could result in research findings that present a lack of insight that could be misleading. Hence, without reflexivity, qualitative research could also have the potential to silence women's voices. That would work against feminist principles.

3.10 Putting reflexivity into action

Reflexivity was used to alert myself to voices that I had not heard before, which contributed to generating meaningful data and interpretation. For example, my experience of being a partly deaf woman (termed in the UK as disabled) has resulted in me experiencing, sharing, and reflecting on understanding and having empathy towards the difficulties that some women have with language, spelling, grammar and sentence structure, all of which is paramount for those studying formal academic courses. This, in turn, can affect the experience of PPD activities with regards to needing more time, effort, support from people and monies to pay for equipment.

Several SA participants in this research told me that they trusted me and knew that I would listen to what they told me because - "you know what it is like to struggle." I listened to what these participants told me about what their difficulties were and had been, with regard to their own PPD. O'Reilly and Kiyimba (2015), suggest that the genuine concern of the researcher should

initiate and enhance a good relationship between themselves and the participant, as this will lead to a more valid and trustworthy collection and interpretation of the data. For example, although I was from a different background and position, I had gained some insight into how being a black SA woman living in poverty can compare to other women, as this can result in greater self-sacrifice and commitment from themselves and their families with regard to finances and time for PPD. I felt humbled that participants found the time to be interviewed and trusted me to tell me about their lives, and their PPD perceptions and experiences. One participant, having received an email from me informing them about the results of the study and my recent presentation to the SA DENOSA conference (2016), confirmed that a positive relationship had formed during the interview process, and at the same time, the participant had also benefitted from the interview process:

"Your study meant a lot to me because you listened to my story that no one else would have time for. Research can be healing for some participants, I mean, just to get the opportunity to ventilate your mind." Rachel, 20, SA

3.11 Reflexivity, the researcher and the participants

Payne and Payne (2004) assert that feminist researchers regard good research practice as attempting to have a non-hierarchal relationship between themselves and participants; that this, in turn, promotes equality within the relationship where women researchers are in a unique position to understand the emotions and experiences of their participants. This creates a platform whereby women can empathise and share some commonalities with other women. Roulston (2010) adds that, at the same time, to achieve transparency in research, feminists must demonstrate self-awareness, in that they too must consider that the shared category of being a woman may not produce meaningful data when they do not share other commonalities, such as race, class and disability. Reflexivity is a key research tool: it is argued that continued self-analysis can help awareness of other voices (Mills and Mullany, 2011). Mathison, (2014) expands her viewpoint, arguing that the

researcher is to be regarded as an "instrument" collecting the primary data, which again justifies that reflexivity must be used within this feminist research to promote women's voices within the research.

Finlay and Gough (2013, p ix) describe reflexivity as a process of *"bending back on oneself"*. Reflexivity incorporates critical reflection on the research process, and awareness of the role the researcher plays within research. For example, the quality of the interview can affect the quality of data generated; the researcher acts as a research tool themselves. The researcher demonstrating sensitivity and self-awareness between the dynamics of researcher and the participants is core to reflexivity, more so in this comparative research that aimed to research both UK and SA women's perceptions and experiences. Mathison (2014) adds to this by stressing that reflexivity is also dependent on the relationship that the researcher has within the research context. As part of my attempts to display transparency, I have discussed this in further detail later on in this thesis (Chapter 3:.10).

Researchers can be viewed as insiders or outsiders. Insider and outsider positions may have an effect on the research process. Braun and Clarke (2013) explain that this also depends on group identity and what researchers share with participants. Within this research, I was viewed as either or both, depending upon the participants' own views. As a woman and as an RN, this gave me basic membership of the group of participants that I was interviewing. As a nursing academic, and not working in a hospital nor carrying out "core" nursing care, I may have been viewed as an outsider – peripheral member (Mathison, 2014). My national identity also gave me dual insider/outsider membership. As a woman born in SA with a British accent and values, my membership was down to the participants' personal interpretations. Some SA participants viewed me with differing membership status; some saw me as a SA, others saw me as a UK person keen to research SA women and others as a white, academic, wealthy woman that could have created distance between myself and them or had the other effect

of uniting myself with other white women. Braun and Clarke (2013) conclude that we are likely to have multiple insider and outsider positions, all of which need to be acknowledged within reflexivity. This brings me to conclude that reflexivity plays a key role within this study, along with it being central to CGT (Holiday, 2007).

3.12 Standpoint, positionality, reflexivity and feminist research

It is argued that the researcher must be aware of their own standpoint, as this is where they start within their research (Ember and Ember, 2009).

Pilcher and Whelehan (2017, p156) add that it is our own view '*that influences by where we stand*'. Hence, what the researcher observes and understands has an impact on their research (Merriam, 1998). They may listen more closely to hear if other women's voices say the same thing or if they say something different (Wolf, 2012). Hessey-Biber (2013) also points out that the researcher must also acknowledge any prejudices or biases they may have, that in turn could have an effect on the research. Ember and Ember (2009) remind us that self-awareness from your own standpoint is also an important factor, because without this we will not be able to see to how this standpoint could potentially have an effect on the weighting that you add to the coding and themes identified in your research.

Hessey-Biber (2013) argue that each individual has their own understanding of the relationship between their own feminist knowledge, women's experience and how women's lives differ from men's (Ramazanoglu and Holland, 2002). It is from this position that the researcher designs and conducts their research. Analysis, decision-making and conclusions are all influenced and driven by the individual's own understanding of knowledge; social background, location, assumptions can all have an effect on the way the research is conducted and the outcomes of the research (Hessey-Biber, 2013). The reader may not support the researcher's standpoint; however,

they should be convinced on how the researcher reached their conclusions (Abbott and Wallace, 1990).

Abbott and Wallace (1990) instead indicate the researcher should use their feelings as a way of validating the process, and use their own experiences, engaging in reflexivity and contributing, as women, to research (O'Reilly and Kiyimba, 2015). They propose that the researcher who is undertaking research and is using reflexivity within it also needs to be aware of their own ontological assumptions, as this is a crucial starting point. The realist researcher supports the notion that social reality exists independently of human interpretation and conception, and human consciousness and social theory is needed to understand and create knowledge and understanding (O'Reilly and Kiyimba, 2015).

This study aimed to create credible knowledge and findings that would give women a voice (Hughes, 2002). This, in turn, could lead to questions around how to overcome or manage any difficulties in giving women a voice in relation to PPD. The results of this study aim to contribute towards knowledge on PPD and encourage further research that could promote better practice in supporting RNs' PPD, both inside and outside of the work environment. To achieve this the methods used needed to consider the issues that could be raised for the interviews were conducted in SA and the UK, both of which were familiar to myself the author, hence it was important to explore my own personal standpoints and undertake some self-reflection as part of my own preparation for the chosen research design.

3.13 Packing boxes: my personal standpoints, autobiographical, and self-reflection on own experiences of having insider and outsider roles.

Abbott and Wallace (1990) argue that whilst all women share experience of being subordinate in society, what they experience may be different from others, and this needs to be acknowledged in feminist research. At the

beginning of the research study I had written a personal profile for my first-year review. It told the reader briefly about my background as an RN, that I lived in the UK working as a senior lecturer, I was born in SA, and I was partly deaf, and that I had an interest in PPD and feminism.

However, having compared this attempt to Delamont's (2003) personal note of herself and how her personal history shaped her interest in her research and influenced her style of writing on her research, I recognised that the initial personal profile did not necessarily give enough explanation for the reasons behind the research design. For I had hidden my own experiences because I had assumed that this was to be expected, in academic text. So, a second attempt was made below, which is far more reflexive than the first attempt that was given in my first-year review. This second attempt now offers clearer links between the autobiographical history of myself, the researcher, and my connections with the study:

SA is the place where my heart started beating. I was born in SA and had moved away to the UK with my British family at the age of three years old. I describe myself as white British and born in SA, my family line stemming from UK and European backgrounds.

Class is often raised as important to declare by many feminists, as class systems have been used to control and suppress women, and women's experiences have been found to differ according to which class they have come from (Delamont, 2003). Beinart (2001) argues that the SA apartheid (apartness) years used class (and race) to discriminate against others, which, in turn, had affected individuals' financial status from wealth to poverty (failing to raise discrimination between women and men). If I had to say what class I was from, I would have viewed myself as middle class, this perception being influenced by my mother. However, my personal life experience of class has been varied, which may have given me more insight into women's

lives.[10] The British Broadcasting Corporation (BBC) 2011, and 2013, Great British Class Survey and new social class model would define me as person of "established middle class", my wealth having come from my occupational status rather than family inheritance (Savage *et al.* 2013).

On reflection of my life experiences and personal values, I do not favour anyone from any class abiding by the NMC's Code of Conduct (2015b; 2018), which stipulates that you must treat people as individuals and with respect. As a result, I have been comfortable communicating with people from all walks of life, seeing them as my equal, or better than me, regardless of age, disability, race, class, religion or culture, for if I had supported apartheid, I may have not been so successful in recruiting participants in this study.

Ali (2000) describes diaspora as when a person is living outside of their common culture for reasons such as migration or dispersion. On reflection, I had always felt some diaspora and regret knowing that the meningitis infection that I had contracted as a baby had affected my parents, their relationship and family life. This had contributed to them leaving SA and returning to the UK. For me, "home" is associated with several places – SA is one of them. There was always a desire to re-connect with my SA roots, and some sense of responsibility to offer some service to SA and give something back to SA, that could help benefit SA and the growth of the now commonly used term "rainbow nation" (Our-Africa.Org 2017).

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[10] My mother's, mother came from a Victorian family that had been upper class; her mother was disowned from the family having married a working-class man. My mother had been raised in a working-class home but was treated at home as if she were from an upper-class background. Then, in her third marriage, she moved to the wealthy elite class. I did experience some of this lifestyle as a young person although I had never lived under the same roof as my mother's third husband. I had also experienced one time being a working-class child, when one of my father's business decisions had a catastrophic effect on the family finances, contributing towards my parents' divorce.

Abbott and Wallace (1990) argue that the feminist researcher must be aware of how their attitudes and values may influence the research process. On commencing the research, I embarked on a reflection upon my own attitudes and values. I approached my research as an opportunity to reconnect myself with SA and its people.

Delamont argued that many researchers take a "short cut" when explaining to the reader their autobiographical history and connection with their research. This important stage should not be avoided or minimalised; instead, it should be used to demonstrate that the author is "the right person for the job", and that also any potential bias or preference should be displayed openly for all to see. By acknowledging my own experiences, it has given me a greater self-awareness and a deeper understanding of how the researcher's connections to their research impacts on the research process.

What I had learnt from carrying out this research was SA has had a complex history that still affects SA women's daily lives, no matter which era they were born and raised in, or what colour skin they have. SA moves and flexes from colonisation, apartheid, to creating and developing its new identity as a democratic '*rainbow nation'* (Our-Africa.Org 2017). Every woman, regardless of ethnicity, has their own story in particular in relation to apartheid, and how it had affected them, before, during and after apartheid. Some women have fought to access education denied to their grandparents; other women with white skin are now fighting to seek employment and education since the introduction of SA's Black Economic Empowerment (BEE) Act (Department of Trade and Industry, 2016). An African friend who was from a scholarly background explained this to me in simplistic terms by referring to Smith's (2009) newspaper article that argued black and white skin still counts in SA's rainbow nation. Smith argued SA people feel the SA history and cannot get rid of some of the feelings and history of apartheid. Smith (2009) argued, *"it is like a scar on their skin that continues to itch";* regardless of whether they personally, had experienced apartheid. This scar is in reference to the history

of SA and its people. This research has aimed to let the voices of women participants be heard. This includes the references that they made to their own experiences, and how it has had an effect on their experiences and perceptions of PPD. For example, in this research study several of the black SA women participants spoke of being the first in their family to go to university, whereas their grandparents could never have had the opportunity to do so due to apartheid. In comparison to the white UK women participants, who also spoke of themselves being the first in their family to attend university, they had differing reasons that related back to their personal family circumstances, class and culture.

3.14 Standpoint as a feminist and disabled woman

My interest in feminism started as I sought to understand the world and my "difference". Like other women, this had brought me to read feminist theory and the differences between women, and at one time I had viewed myself as a liberal feminist who wished for equality (Dodewaard Van, 2017). Feminist Suki Ali (2000) spoke of wanting to intellectualise the injustices of her life, the privileges and the disadvantages. Whereas I had always felt and had been extremely aware that the equal opportunities policies that were introduced into the UK during the 1980s and allocated funding for educational support and given me, as a partially deaf person, wearing two hearing aids, a chance to survive in this world, to earn a wage and support myself independently. Even though things, at times, still did not look or feel very equal to me, who was "different" from others. I shared this intuition with Ali (2000), who also inferred that she had observed that there were many differences between individuals that only she may have seen, because she was different too. On reflection, as a lip reader, I can often see what is happening before I hear and listen to what is being said; my own personal viewpoint is that "observations say it all – spoken words do not always speak the truth or reality". For this reason, I could not regard myself truly as a liberal feminist. Bryson (2016) states that by placing the main focus on equality for women,

but not necessarily supporting the diversity and difference of women, with regards to their social roles, and the biological differences of women, this may have implications on their lives that raises issues for many feminists. For myself, as a disabled woman, I will never be able to compete against others who are not as disabled as myself. Though I support their ideas and concepts up to a point, my stance is situated with the socialist feminists, who support the concept of difference and challenges some of social constructions of difference.

Being partially deaf and having attended a primary school that specialised in education for deaf handicapped children I was very aware of my difference in comparison to other children around me. I was also aware that some people living in the deaf world had no intention of integrating into the hearing world and were described as having "a chip on their shoulder" by those from the hearing world. The function of culture is described by Browaeys and Price (2015, p13) as '*integration, adaptation, communication and expression'*. This definition suits my own understanding of culture, as I have experienced living in several cultures: the deaf culture, the hearing world culture, the SA culture and the British culture. It may be that because of my own experiences of being an insider and outsider, living in what could be argued four different cultures, in which two cultures (the British hearing culture) overruled and overshadowed the others, turning them into sub-cultures, these experiences have given me more insight into cultures and how the norms and values continue to move, change and inter-relate with each other. It had also given me another way to connect in particular with the SA participants in this study, who were living and working in the Western Cape culture, away from the culture that they were born and raised in.

The category of being deaf, and therefore labelled disabled, gave me minority status. As a result, it brings a tendency to naturally gravitate to forming friendships with others who are also different and perceived to be from minority backgrounds. I would quickly become very vexed should I

observe (not necessarily hear) any negative behaviours displayed towards others from a minority background because the learning behaviour of the deaf culture is to look after each other. This may also be a reaction from the set of values also held within the professional culture of nursing, in that all should be treated with respect (Browaeys and Price, 2015; NMC, 2015b).

3.15 Packing boxes

My educational years as a child were focused on learning to lip read, developing my speech and communicating with the hearing world. Though I was an avid reader, my grammar spelling and understanding of the English language is still a daily struggle, as my first language was deaf language. My immersion into the UK deaf culture came to an abrupt end when my mother was told by my teacher that I did not really need much education, as there was no point, because when most deaf children left school, they just ended up packing boxes. "Overnight" it felt that I had been removed from my deaf culture, and placed into the local comprehensive school, with additional support of speech therapy, spelling and grammar. I would argue that, in truth, my real education came on joining the Guide Association, in which I excelled. It was this experience that told me (as well as my mother) that if I put as much effort as I did into my Guiding, then I could do the same in my education. Having learnt to listen, I re-sat qualifications at college; I was lucky enough to be accepted into nurse training, at a time that I was told that I would be the first trainee that they had ever had who was partly deaf and wore hearing aids. I was breaking the stereotypes and lucky enough to be supported by an open-minded nursing leader.

My deafness gave me a sixth sense and observational skills that were invaluable in working in the emergency operating theatre. On completing my nursing specialist course based at a university I started to think that "I could do it". The degree I chose to do was Women's Studies because I wanted to gain a better understanding of society, the way it was structured and

established, and the effect that this had on my own and other women's daily lives (Abbott and Wallace, 1990).

My thoughts were that, on completion of my degree, I could work somewhere that would be able to support women's development and help empower them. My career led me to working for the NHS within the education and training department. It was there that I was lucky enough, as a line manager, educational adviser and as a Masters student, to experience what I would personally describe as the "golden years" of the NHS in which the concept of support for those engaging in PPD was valued as a priority within the organisation. Support meant getting paid work time to undertake PPD activities and financial agreement from employers to pay fees for my own academic studies. In my own experience, and having spoken to many RNs, nursing tutors and academics, this has now become a rare experience in today's world. This disturbs me greatly, as I have personally seen the effects of this withdrawal of support on women's lives.

I moved into the job at a NW English university in the position as a senior lecturer, whereby I could influence and support development for RNs, and I could, personally, make a difference to individuals. I have worked hard to get to where I wanted to be; with every mountain I climbed, when I stood at the summit, I could then see the next mountain that I wanted to climb. I did not want to climb it just for myself; I wanted to climb it and bring others with me. Supporting the belief that anyone can do it, that they just need some help to get there – some need a little, some need a lot, but with hard work, grit and determination they can get there, just like me. For without the kindness and friendship that has been shown to me, I would not be where I am now. It is probable that from my own experience, it has driven me to be a nurse educator, and a role model for others who are deaf and wear hearing aids and a role model to demonstrate that deaf people can work in healthcare environments. Arguing, and telling people, that they can, with help and support from the others around them, overcome the difficulties. Drive, deaf

loneliness (Chapman, 2006), Christian faith, determination, stubbornness and laughter have helped me overcome the difficulties, ranging from oppression and unkindness from others (some due to ignorance and others not so) to simple "deaf spelling and unique terminology", which some other academics deplore, whilst at the same time making students smile in recognition that we are all human and not perfect.

On sharing my reflections of my semi-autobiographical stance, it demonstrates that I have had a wide range of experience living in different cultures. That my beliefs and values are that regardless of what culture of background you come from, by employers reducing support, this is affecting the PPD of women RNs. It is now more important than ever to understand the difficulties that women face with undertaking and engaging in PPD, and to seek ways to overcome them. On reflection from having had my own experiences, it has established, for me, a lifelong interest in wanting to understand to what the difficulties are for women, and there are many ways to overcome them. This may explain why this research study involved travelling halfway across the world three times (funded and self-funded), to research a subject that I passionately believed was worth knowing about, that would be of benefit to RNs in the UK, SA and worldwide, as these women's voices need to be heard.

To summarise, this section described how the research design was selected to incorporate the rational for the chosen qualitative methodology. Use of a sociological feminist approach, with CGT, and reflexivity. Looking at my own positionality had brought me to reflect on my own standpoint and established my own knowledge and experience that also influenced the design of this research study.

3.16 Setting and sample

Arthur *et al.* (2013) advised that when considering where the geographical location of a study could be undertaken and what features it would need to have, for the study to be a success, the researcher needed to have clarified that the people working and studying in this location would have the characteristics that had been identified for the sample inclusion criteria.

This study was not designed with the intention of having samples of women that represented each geographical province or region. For a design of this scale would have needed substantial funding and a great deal of time. Instead, it aimed to provide a snapshot of the reality of women's experiences and perceptions, aiming to recruit a variety of women from different backgrounds and experience and to follow theoretical sampling after the initial data analysis. Additionally, the research design had to adhere to the financial limitations, that put constraints on time outside of paid work, and costs associated with travel.

This study recruited WRNs from two universities in SA (Cape Town) and from three universities in the UK (Edinburgh and the North of England). The choice of SA universities and geographical location was influenced by the SA and UK government's recommendations of safe areas in for visitors and tourist (Tourism.gov.za 2017). Cape Town in the Western Cape Province was chosen, as the universities in this area are known to attract people who wish to develop themselves academically as well as in their professional practice. In the Cape Town area, many people wish to stay and live there because the employment prospects are much better in comparison to other provinces (Mqolozana, 2008). In Edinburgh, they also had students that are local, from afar and from other countries, whereas the other UK University that I recruited from had fewer students from these backgrounds.

In SA the Cape Town area was also regarded as suitable for this study design because of the close proximity between the two chosen universities

and their satellite sites. This enabled me to have one place of accommodation from which to base myself, keeping travelling time down to two hours each way and travel costs to a minimum. These locations were viewed to be safer areas with less risk for someone like me, a single white woman travelling on her own. The same principles were applied in the UK whereby three universities were chosen close to where I lived and worked; 1 university in Northern England and 2 universities in Scotland.

For the comparison to be valid, Schraf (2016) argues the researcher needs to be clear that these two countries could be successfully compared against each other by establishing the membership of a particular group; and in this research, their participation in a particular context. To ensure the design resulted in a credible study the selection criteria was designed with more thought to what range of women were needed for this study (Creswell, 2014a; Ormston, 2014).

At the beginning of this study the purposive sampling aimed to select participants with the following characteristics and experiences (Moule, Aveyard and Goodman, 2017) with the plan to change theoretical sampling to aid the development of theory by targeting those that I thought would be able to add insight (Arthur *et al.* 2013).

The initial inclusion criteria set were: (a) female RNs with at least one year's post-qualificatory experience working in the NHS or for a private employer. Who were or who had (b) recently completed PPD activities based within the university setting (regardless of what level of academic study they were undertaking or had recently undertaken). (c) To be of a SA or UK nationality, and lastly (d) to able to speak and read in the English language (all the universities chosen in this study to recruit participants used English as their official language within all teaching and assessment). Having English as the spoken language made sampling for interviews more achievable, though for many women English was not necessarily their first language. I had to be

mindful of this when conducting the interviews and analysis, establishing if any misunderstandings had taken place and acting on these quickly.

Male RNs were excluded from this study, as the research design used a feminist approach based on gaining knowledge of women's perceptions and experiences. Those RNs qualified for less than a year were also excluded, as it was regarded that they would not have enough post-qualificatory experience of PPD.

Time and financial constraints influenced the research design and the size of the study. It was perceived at the beginning of designing the research study that a small sample would be taken from each country, as this is common for qualitative comparative research between two countries (Ember and Ember, 2009). It aimed originally to have a minimum of 20 participants, 10 from each country, so that some comparison could be made, with one planned trip to SA. In the first round of interviews, participant numbers were 6 in the UK and 10 in SA. However, in order to complete theoretical sampling and undertake comparison and reflexivity, participant numbers were increased in a subsequent round of interviews to an additional 8 UK, 14 SA and finally a further 1 in the UK. This required two additional trips to SA. The final numbers of participants were 15 in the UK and 24 in SA, giving an overall 39 participants (See Appendix A and Appendix D for population and nursing figures).

3.17 Preparing to undertake fieldwork in SA and the UK

Risk assessment for this study was undertaken to assess the risks that may have been posed and the appropriate documentations were completed for my employer and my university of study. Identification of passport requirements, vaccinations, and insurance were explored and acted upon. Travel itineraries were provided for the three trips to SA. The lone worker policy was adhered to throughout the study. When using accommodation in

SA, reception staff at the venue were provided with the names of the key contacts within the two universities and my itinerary of the day. They were also asked to tell me if anything happening in the daily news indicated if it was unsafe for me to travel, which happened several times (University of Cumbria, 2017). I reported back to the accommodation on my return, and avoided driving at night using main highways and streets (Gov.UK 2017; The University of Edinburgh, 2017). Other measures taken for safety were that I carried a mobile phone that was fully charged and only used for my SA research trips (mobile phone sim card numbers were discontinued after every trip). I had key contacts at both SA universities who were emailed, on a daily basis, my itinerary for the day, and could contact me via email or mobile. Both of these contacts had the phone and email of another key person who had previously worked at my place of employment in the (UK) and had knowledge of the SA universities. I reported back to them on a regular basis through email and phone to update on my progress and to seek advice on any difficulties that I was experiencing. Additionally, my supervisors in the UK were emailed, and Skype and telephone calls were made during my trips in SA to discuss travel plans and itineraries were, on occasions, discussed. Meetings with participants were mainly held on the university or hospital sites, whereby security was available, and on odd occasions at public cafes.

To summarise, features required in this study that would complement the research design were aimed to be comparable with each other: main city universities, with validated nursing courses being delivered at various levels from degree to masters or PhD, and which held a reputation of recruiting RNs locally and from across the country (hence, women from city, semi-rural and rural areas all participated in this research). Locations were chosen, with safety and minimal risk of harm being the utmost priority.

3.18 Sampling

The sampling began with purposive sampling according to my inclusion and exclusion criteria and then moved to theoretical sampling as the analysis progressed (Arthur *et al.* 2013, Millar and Birch, 2012). Creswell (2014a) argues that in qualitative research the initial design needs to be flexible, not rigid. For as the researcher *enters* the field, some of the phases of the research plan may change. Asserting that in qualitative research it is key to *'learn about the problem or issue from participants and to address the research to obtain that information needed',* Creswell (2014b, p186).

Walliman (2011, p189) proposes that the size of the sample is determined by the *'amount of detail required in the analysis of the data',* and that larger samples are more convincing of the validity (Grey, 2018). Braun and Clark (2013) postulate that in qualitative research a medium sized study would range from 15 to 30 interviews, with larger studies being 50 or more. Neither of these authors made suggestions for the sample size for comparative studies between two countries; Ember and Ember (2009) suggest that this may be due to so few research studies using this design, because they are often avoided due to the implications of financial costs and time. Braun and Clark (2013, pp55-56) conclude that data collected cannot be too shallow otherwise the credibility of the findings would be questioned. For analysis to take place a *'certain amount depth is required to gain rich and meaningful data'* only then can it be grounded into theory.

In CGT it is recognised that *'initial sampling is where you start whereas theoretical sampling directs you to where to go',* Charmaz (2006, p100). Flick (2018a, p87) adds to this by stressing that theoretical sampling is used to *'elaborate and consolidate the theory that is developing'*. O'Reilly and Parker, (2012) argue that the researcher must acknowledge if the number of participants is regarded as stunting the process, hence the participants may meet the criteria, but the data collected has not achieved enough depth, of which I experienced in this study. Parahoo (2016) adds that the number of

participants cannot be fixed, as theoretical sampling is most likely to take place as the research explores new data, developing codes, categories, sub-themes and themes until data saturation is reached. The researcher is then satisfied from having collected data, that the relationships between the codes, categories, sub-themes and themes can be confirmed. I started with purposefully sampling starting with 6 UK participants, followed by 10 SA participants. Having reviewed the transcripts I found the data from SA narrow with consistent views, hence the data did not have the wide range that I was needing for this study. To undertake the next stage of theoretical sampling, I chose to interview a further 8 UK participants. I then returned to SA with the aim to target potential participants of whom I thought were best able to provide clarity to questions and assist in developing the themes, this was achieved through interviewing 14 participants and finally 1 UK participant (total 39 participants). For even though I had knowledge and personal experience as an RN undertaking PPD activities, as I engaged with the data, my perspectives grew and changed and new categories began to emerge in the data that needed to be explored in further depth (Charmaz, 2008). This process included what Charmaz (2008, p161) described as *'probing beneath the surface; comparing data, checking hunches, refining emerging ideas, and constructing abstract theories from data analysis'*. The only way to do carryout this iterative process was to recruit more participants (from a wider range of age groups, and WRNs who had experienced working in range of specialities and educational achievements from modules to PhD) and ask further questions, collecting and analysing data, and discussing with participants of what the results were revealing. Theoretical sampling was used until reaching theoretical data saturation of the theoretical categories (Charmaz, 2008). Theoretical sampling allowed deeper exploration of the emerging themes around perceptions and experiences of PPD, and ultimately more credible findings (p153, 155 and 164).

The suggested sample sizes for comparative studies undertaken into two countries is debatable. The researcher needs to make the final decision to determine when theoretical saturation has been reached based on the depth of the data, the categories and the relationships between them and the emergent sub-themes and themes. Braun and Clarke (2013) suggest that a research study using GT with a research question that explores understandings and perceptions would need to be a moderate to large sized study; this study had a total of 39 participants: 15 UK and 24 SA. This study aimed to recruit participants from both countries, as I explored the data, I sought participants who would provide further insights on PPD that would assist in my theoretical coding.

3.19 Recruitment

Email correspondence was used to inform the Universities about the study and to gain advice on the university processes for permissions, along with the key supportive gatekeepers and other university staff who assisted in giving out information leaflets/forwarded emails on to students that they thought would be appropriate for the study (Appendix F).

The recruitment leaflet was designed to be used for recruitment purposes (Appendix F). The leaflet outlined the study and a picture was placed on it so that people would know what I looked like. Contact details included my student email and my work mobile number. Hence, potential participants could contact me in different ways. I spent time at each university campus site so that should a potential participant be on the campus and was willing to participate in the study, I would be able to respond to them quickly.

These leaflets were given to lecturers, RNs who were studying or working at the universities and left in public places. They were also sent to students via the university email system, lecturers were asked to place an email advertising the study and request for participants on to the students' websites.

Once potential participants responded, they were given by hand or emailed the university formatted consent form and participant information sheet (PIS) (Appendix G), the DDS (short answer questionnaire) (Appendix H), along with confirmation stating the date, time and place of the interview. Each form was amended by myself to incorporate information unique to the university. Information from the DDS were used to present details of the sample listed in the following section.

Hodges and Thomas (2010) allege that "outsiders" need to undertake long-term planning to become involved with the group that they wish to research. Introductory letters were sent to the Heads of the SA nursing departments. This included information that confirmed myself to be a credible person to undertake research on this subject, declaring myself to be an RN, nursing academic and PhD student. It explained my interest in wishing to research RNs' perceptions and experiences of PPD and that my data collection method would involve recruiting RNs and undertaking interviews with these voluntary participants on an individual basis.

As previously discussed, the area of the country that I wished to conduct my research in had been decided: two universities in the Western Cape, SA and three universities in the North West England and Southern Scotland, from which ethics permissions had been gained (see appendices 4). Discussions with my PhD supervisors, who they knew, and searches on the internet, were used to establish and confirm the universities' Heads of Departments. Emails were sent with information about the design of the study, with a request for permission to be given to carry out my research at their university. This included the PIS, recruitment leaflet and/or email, the consent form, the DDS, and the interview schedule (questions) (see appendices 4). The response was positive, and I was advised to commence gaining ethics permissions attaching the required information as per each university's ethics policy.

Arthur *et al.* (2013) spoke about the disadvantage of gatekeepers. They had experienced some gatekeepers as having their own views about who could participate in the research, despite having received information about the criteria for participants. Arthur *et al.* (2013, p126) advise that the researcher needs to *'be vigilant in making sure that the sample meets the required criteria'.* By identifying that some men's names had been passed on to me, I had to explain to these men and university staff that the research was about women, not men. In SA, having completed the short questionnaire (DDS), two women were identified as not having SA nationality but they both wished to attend an interview to meet with me and tell me about their perceptions and experiences of PPD as an African woman. I honoured this and learnt a great deal, as the sacrifice these women and their families made to support their PPD in SA was inspirational.

The SA professor who was my key contact guided me throughout the ethics permissions process. Gaining ethics permissions took a lot longer in SA than in the UK. One of the reasons for this is that the processes were not clearly documented and that it was difficult to get hold of the dates of the various meetings when the details of my research study needed to be presented, and approved before they went through the next stage. None of these processes or policies were able to be accessed via the internet. I gained ethics permission from this fifth university, two weeks before I was due to arrive in SA (see appendices 4).

I returned to SA for a second trip to collect data. It took over a year to gain ethics approval from the fifth university. However, the advantage was I was then familiar with lecturers and staff that worked at both universities, they had met me and knew about the research study. I had examined the data collected so far and was able to say what progress I had made with analysis as I started to undertake the process of abduction through questioning, analysing and reasoning with the emerging concepts (Millar and Birch, 2012). It also gave me the opportunity to explore questions that I had made with

regard to the SA culture and the RNs' work environment. On my return for the second time, I was supported by a number of SA staff members, who took the time to help and guide me in recruitment. Nurses willingly engaged in conversations that allowed me to undertake data analysis that led to theoretical data saturation by ensuring that the categories that I had identified, were accounted and the relationships between them were tested. Additionally, I established that some data analysis was not sufficiently addressed due to a lack of data. For example, I only recruited a few RN's who were in managerial positions therefore whilst my findings represented WRN's perceptions of line managers, it did not represent line managers perspectives (O'Reilly and Parker, 2012). I was successful in recruiting WRNs of differing lengths of experience, specialism and ages. I recognised at the being of the study that there was a risk of having participants consisting mainly of one age bracket or very similar number of years' experience which could influence the findings and not be representative of WRNs[11]. Theoretical sampling included seeking participants from differing age, speciality and experience, who offered more depth and breath, and enabled me to explore issues and concepts identified with a wider range of participants. One commencing theoretical sampling participants also took part in member checking as part of ensuring the credibility and trustworthiness of the findings. Savin-Baden and Howell Major (2013) describe member checking as when participants read the transcripts and feedback on them. Whereas Holloway and Galvin (2017, p311) explain that one of the purposes of member checking is to *'find out whether the reality of the participants is presented'.* As a comparative study, I needed to be clear

[11] Richards and Potgieter's (2010) SA study on RNs perceptions on continuing formal education used a convenience sample. Though they did not acknowledge it in their limitations of the study they had acknowledged that the majority of participants were within one age bracket, and the majority of participants were very experienced senior RNs with the mean number of years experienced as 21.5 however no reference was made to the number of years experienced gained working in healthcare before gaining nursing registration.

what participants were making reference to, and how this 'fitted in'. This was achieved through conversations within the interviews, and outside of the interviews.

This comparative research study started with collecting data from the UK, from which analysis of the data commenced. Following this, interview scripts from my first trip to SA were read, and comparison and analysis of the data started to take place. Constant comparison took place as I went on to collect further data from the UK. I then found that I did not have enough depth from data from the first trip in SA, hence I conducted the second trip to SA to collect data that assisted in identifying the variability between the categories (O'Reilly and Parker, 2012). Finally, I collected further data from the UK in order to have more WRNs who had experience of different specialities (other than general nursing) the data adding further depth leading to reach data saturation in which the relationships between the categories had clarified and the theory could emerge (O'Reilly and Parker, 2012).

3.20 Sample recruited for this study

For the UK sample the majority of the participants recruited were from the English UK university site. This was in a predominantly white British area; all of the 15 participants described themselves as white British. The 2011 England and Wales census recorded white British as 86%. In the SA sample I recruited black African (9), coloured (12), white SA (2) and Indian (1), a total of 24 SA women. The SA 2011 census (Statssa.gov.za) recorded black African as 76.4%, coloured as 8.9 % and white as 9.1%. The sample from SA therefore had some representation of women in their country, but not all races[12]. This was only a medium sized study. In 2019 there were 661,000 registered nurses in the UK, (Statista.com, no date). In 2018 there were

[12] There were no participants from the following ethnic groups. Terms used in SA and the UK: Asian, other SA ethic groups, white, other, Pakistani, mixed race, Bangladeshi, white Irish, black Caribbean, black African (UK), black other (UK).

57,725, 606 registered nurses in SA (SANC, 2019) (See Appendix A and Appendix D for further details on UK and SA populations and nursing populations).

The participants recruited in this study represented a wide range of backgrounds with regards to age, marital status and the number of children the women had. There was also a range in the number of year's post-qualification experience they had and the range of specialities that they currently worked in. PPD activities can involve gaining academic qualifications; in this sample these are women who have achieved a range of academic qualifications. This information was collected via a short answer questionnaire (DDS) (Appendix H) that was completed by participants prior to the interviews commencing. This data was collected in order to distinguish it from other studies identified in the literature review in that the sample represented a wide range of women from varied nursing specialities and backgrounds.

Whilst the characteristics of the sample are given below, it needs to be noted that not all questions asked on the short questionnaire (DDS) were answered by participants.

Women from a range of family statuses participated in this study (Tables 2,3,4, 5, 6 and 7). It was felt that there was no need to provide information on whether these women were from SA or the UK, as the purpose was to demonstrate that the women that participated in this study came from a range of family backgrounds.

Family Status	single	Partner	Married	separated	divorced	Widowed
Number of women	6	1	21	2	6	1

Table 2 Women's family status

The majority of women in this study were married, 6 women were single, 6 women were divorced, 2 separated and 1 widowed. It needs to be noted that some women in SA have remained married, even though they do not live with their husbands. In the black SA community, this is often to avoid social stigma.

Number of children	0	1	2	3
Number of women	10	6	15	8

Table 3 Number of Children

The majority of women had children however 10 women did not have any children.

Age range	25-30yrs	31-40yrs	41-50yrs	51-62yrs
Number of women	8	11	12	7

Table 4 Age range of women

The range of women's ages in this sample was from 25 to 62 years old. Most women were aged between 31 and 50 years old.

Post Qualification experience in years	0-5	6-10	11-20	21-30	31-40
Number of women n=39	14	4	7	10	4

Table 5 Post Qualification experience in years

Whilst 14 of the 39 women had 5 years or less experience as a WRN, it needs to be noted that many women had worked in healthcare in other caring roles before undertaking their nurse training. Hence, PPD perceptions and experiences may have been based on their work in healthcare. Women in this sample had a range of experience as qualified WRNs. I felt that it was important in this study to have women who were in different stages of their careers, from starting out as a recently qualified WRN, to mid-way in their careers, and to coming to the end of their careers, as this would present a far more balanced representation of WRNs and their perceptions and experiences of PPD. The data collected allowed me to undertake comparisons and undertake analysis that led to identifying codes that were grouped into categories, Millar and Birch (2012).

Many SA participants within this study, unlike the UK participants, will have had experience of being governed by the apartheid government. (See Appendix D for background information on the governance structures). Within this research study, women may be found to make references that compare the differences and reflect on their experience and perceptions now they are being governed by SA democratic rule.

In order to highlight any differences between RNs in SA and the UK, brief comparisons on their demographic data have been made. (Further information on cultural, social and organisational differences can be found in Appendix A and Appendix D.)

Country	Rural	Semi-rural	City	TOTAL
UK	2	2	5	9
SA	1	3	17	21

Table 6 Participants location

In this sample, participants lived and worked in a range of areas, however it was expected that a higher number of SA participants would state that they currently lived in a city. It was noted that several SA and UK participants chose not to answer this question.

Women in this sample worked and had experience in a range of specialities: adult, paediatrics, learning disability, mental health/psychiatric/forensic, midwifery, research, operating department, intensive care/high dependency units, community, counselling, medical and surgical. The majority of women worked full time.

They worked at the lowest-graded pay to the highest-graded pay within job roles that were classed as junior to senior nursing roles, in education roles, management roles and clinical specialist roles. It was not possible to create a table to compare these, as there are many classifications that the two countries used with regards to roles and pay scales, and some women in this sample did not wish to declare their salaries/or grades of pay, or the jobs that they did. Women in this study had experience of working for: the public NHS, private healthcare employers including charities, education for universities or colleges, self-employed, agency, and one person had worked in the army[13].

[13] As expected SA women in this study were reluctant to state all the employers that they had worked for, and some declared all of the types of employers that that had worked for. It is known that many SA women RNs have more than one job, "moonlighting" is now being heavily policed by SA employers, in some work contracts they threaten immediate dismissal, Unique HR Directions (2016); Econonex (2013); Rispel.L. and Blaauw.D. (2015).

Participants had undertaken and achieved a range of academic courses/modules and qualifications. Table 7 demonstrates that the sample obtained was a representative sample of experience and achievement of PPD formal activities (Pilcher and Whelehan, 2017).

Women studying at differing levels of study	Short course or modular study (at any academic level)	Diploma	Degree	Masters	PhD
Number of women	5	7	2	13	4

Table 7 Women studying at differing levels of study

The majority of participants had been or were currently studying part-time with six SA participants studying full-time on a programme that required assessment of both academic and clinical skills. The above Table 7 demonstrates the experience that these women participants had, recording the highest academic qualification being studied for/achieved from courses or modules to PhD. Nurse training is now undertaken at degree level in both countries; therefore, it was predicted that the most common level of postgraduate would be at Masters level.

To summarise, the purpose of this section was to highlight that the aim to recruit a representative sample of WRNs from both countries. The main aim was to seek a theoretical sample in order to develop and test out the categories through CGT.

3.1 Ethical considerations

Ethical principles are focused on integrity, honesty and respect for participants involved in research. Research that involves any human subjects must undergo an ethics review, which aims to ensure the participants'

dignity, rights and welfare are protected (The University of Cumbria, 2016). In preparation of the ethics applications, reading around the university, UK and international policies relating to ethical principles and practice was undertaken (Oates, 2006; Edwards and Mauthner, 2012; Israel, 2015; The University of Cumbria, 2016). Hodges and Thomas (2010) state that the primary aim of ethics committees is to protect participants.

The research study was designed with the ethical principles in mind: beneficence, non-maleficence, justice and autonomy (Tarling and Croft, 2002; Oates, 2006; Walliman, 2011). Oates (2006) states that when designing research, the researcher should be focused on the impact it could have on those participating in the research and address the ethical principles. To assess the risk of potential harm and minimise the risk of harm (non-maleficence), it was recognised that some of the questions that focused on asking participants about their experiences of PPD could result in the participant talking about both positive experiences allowing them to reflect on their achievements (beneficence) and negative experiences (non-maleficence). By disclosing and talking about their experiences, participants could become upset. Therefore, to ensure that participants would have support after the interview, information on the availability of counselling within the university was placed on the PIS and on the recruitment leaflet. The details were changed according to which university the participant was studying in.

To achieve beneficence, it would be explained that new knowledge gained from the research would hopefully benefit women, by expressing RNs' experiences and perceptions of PPD from both SA and the UK, providing insights into how women approach, manage and experience PPD.

Ethical principles express the need to support autonomy of the participants (Punch, 2016). To achieve this autonomy, it was assured that participants had access to all the necessary information to be able to make an informed

decision. Bell (2014) establishes that informed consent can only be achieved when potential participants have enough time to read and digest information, and also have the opportunity to ask questions prior to consenting. It was planned for all information about the study to be emailed to potential participants after they had expressed an interest in participating. I also carried hard copies with me of the documents with me should a potential participant approach me for further information, and for those coming to meet me for an interview who had not printed out the documents.

To aid autonomy and avoid potential participants feeling pressured into participating in the research and engaging in coercion (Hodges and Thomas, 2010) the recruitment leaflets were handed out by me and left in the university classrooms/sitting areas for potential participants to read and/or for recruitment emails to be sent (by myself or by others) to potential participants with the information attached. The information on the leaflet and on the email provided my contact details, allowing the participants to contact me, should they wish to do so.

Reassurances about anonymity were given to participants. Bell (2014) claims that true anonymity is when the researcher cannot tell which participants said what. With the number of participants, and the timescale in undertaking the PhD, it was recognised that by the end of the PhD the chances were that I would no longer be able to tell who said what. However, I acknowledged that significant experiences that participants told me about during the interviews would be remembered, and that I may or may not remember the name of the participant. The code number assigned to each participant enabled only the location and basic demographic data to be identified.

It was also explained that by having participants from more than one university, from two different countries, and using pseudonyms and numbers, this would considerably reduce the risk of any participant being identified through the use of direct quotes in the findings. Any direct quotes that I

thought could identify the participant and, hence, breach anonymity and confidentiality would not be used or, as Hodges and Thomas (2010) suggest, that data would need to be presented in a way that would prevent participants from being identified. Additionally, as a registered nurse, it was explained that I would be bound by my Code of Conduct; however, the subject of PPD was not likely to raise any issues with regard to potential breaches of nursing practice (NMC, 2015, 2018).

A further ethical principle is that participants should give free and informed consent to take part. Rees and Glasper (2016) expressed the importance of spending time with the participant to ensure that they had understood what the research study was about, arguing that by repeating information that had already been presented in written form on the PIS and not just focusing on the consent forms. Before commencing the interviews, participants were asked to if they had received and read the PIS and if they had any further questions to ask before the interview commenced. For those participants that asked about confidentiality, it was explained that direct quotes would be used, and that true anonymity could not be guaranteed although any identifying data would be redacted as far as possible. They were reminded that this study would be part of a PhD thesis and that dissemination would be in the form of publications and presentations in both the UK and SA. Participants were reminded that they could stop the interview at any time, should they need to. If they wished to withdraw their participation during the time that the research study was being conducted, this was their right (Tarling and Croft, 2002). Tarling and Croft (2002) support these practices and propose that building a respectful relationship and acknowledging individual participants as human beings would allow participants to be autonomous in their decision-making.

Additionally, the standard practice of offering refreshments to participants in the form of drinks and biscuits to ensure that they were comfortable was followed; this demonstrated an appreciation of the time and effort participants

had made to attend the interviews, as no monies for expenses could be offered (reducing any ethical concerns with regard to coercion or exploitation). When in SA, where possible, attempts would be made to try to book rooms with air conditioning. Where this was not possible, the room temperature was checked to ensure it was comfortable for both the participant and myself since on occasions it could exceed 30 degrees.

Feminists Millar and Birch (2012) assert that power can influence and change the relationships between the researcher and participants in both a negative and positive way, and that this needs to be considered within a study, drawing upon ethical principles that promote good research practice (Tarling and Croft, 2002; Oates, 2006; Walliman, 2011). In the recruitment leaflet, I chose to introduce myself firstly as a woman, a PhD student and RN, attaching a photo. Then secondly, I introduced myself as a senior lecturer based in the UK, as I did not want to use my position of power to influence others to be involved in the study. I did recognise, however, that I had to be honest and, for some, knowing that I worked in academia could offer reassurance that the research would be undertaken in a professional manner, and the findings would most likely be presented and published.

Good ethical research practice includes the researcher being aware of the issues that may occur and to reduce any issues arising during the interviews, and limit bias where possible (Moule *et al.* 2017). Braun and Clarke (2013) list a range of issues that they warned may arise when undertaking interviews, which were regarded to resonate within this research: dual relationships with participants, interviewing strangers, interviewing across difference, and interviewing people who occupy societal positions of greater or lesser power than you and participant stress – these all needed to be taken into account when carrying out reflexivity within this research.

When predicting the issues I might come across in my SA research, I was aware of a warning that Hodges and Thomas (2010, p91) made in that *'some*

communities may have a history of negative experiences with research groups and may be unwilling to participate in further research projects'. Black SA history is peppered with negative experiences, not from research groups but from the hands of white people and from the government (Beinart, 2001; Nattrass, 2016). I was aware that some people would treat me with suspicion, until they had gotten to know a little more about me and my interest in the research topic. It was important for participants to have some autonomy (pp 140-141) this was achieved by encouraging participants to be actively involved in the interviews and to share and discuss with them their perceptions on the research findings.

Participants in the study were volunteers; the majority had not met me, the researcher prior to the research interviews. A small minority of participants had met me within my work role. Before commencing the interviews, time was spent talking to the participants, as many of them had not completed the questionnaire and they were asked general questions about the weather or how far they had travelled, allowing rapport to build before the interviews started. This is regarded as good practice, as it facilitates a smoother and more effective interview (Braun and Clarke, 2013). A small number of UK participants had known me within my professional role, as either a work associate, or as a student studying at the university that I teach at. These acquaintances or dual relationships had the advantage in that a rapport had already been formed. Several of these participants disclosed personal information that I had not known. Ethical practice resulted in this information being excluded from the data and was not discussed outside the interview room, unless the participant raised the topic themselves. Awareness of potential researcher interview bias and the Hawthorne effect on participants were kept in mind before, during and after the interviews (Thomas, 2017).

Prior to commencing the interviews, informed consent was achieved by discussing details of the research study in the PIS and giving participants the opportunity to ask any questions. Participants were reminded that

participation was voluntary, and they were thanked for their time and efforts to attend the interview. Participants were then asked to sign the consent form and given the short answer questionnaire (DDS) to complete. When filling out the short answer questionnaire, the participants also had the opportunity to ask any questions about the research or the questions asked on the short questionnaire. Additionally, if I had any questions on the answers given on the questionnaire that were incomplete, then these could be clarified. This process ensured that informed consent had been achieved, and the consent form was signed (Rees and Glasper, 2016). The short answer questionnaire (DDS) also included a request for an email address as a contact. It would be optional if the participant wished to receive a summary of the research findings at a later date in the form of a powerpoint presentation. These hard copied were stored in a lock safe in a locked office. Dissemination of the findings is good research practice, as it gives the participants the power to read the research findings and make any comments if they wish (Braun and Clarke, 2013).

In this research study, applications for ethics permissions were undertaken and obtained from five universities: 3 in the UK and 2 in SA (pp 130-132). Each university's ethical application procedure was followed, using their own stipulated university documents. The standard documents used for all ethics applications were: an ethics application form, a consent form, a PIS and the short answer (DDS) and the interview guide (see Appendices 4-8). These documents included information for participants on my supervisors' contact details, if they wished to complain about the research. On the ethics forms a declaration was also made in that I had been successful in gaining funding via a travel scholarship for those undertaking research in healthcare (The Dowager Countess Eleanor Peel Trust, 2017). Receiving this funding would have no effect or influence on my conduct or results of the study, as there were no conflicts of interest.

It was decided to approach the UK universities first, as I would be more familiar with the process, and then the SA universities. For each university ethics application, I downloaded and completed the university's documentation, by cutting and pasting information from the original forms and information that I had sent at the beginning, ensuring that the same information was provided but on the forms that were used by each individual university. Gaining ethics permissions and approval from the first UK University aided my application to other universities. The second UK University automatically granted me permission on having viewed the evidence and ethics approval letter, including my acknowledgment that I understood their university's ethics policy and procedures. The third university required me to make further amendments before offering ethical approval. In addition, they set stringent boundaries with regards to recruiting strategies. All the other universities allowed me to send emails through lecturers (who often volunteered to be points of contact), and to meet and talk with potential students. Whereas with the third UK university, I was told that because I was not doing my PhD there, they would only allow me to put a poster up on a very crowded student notice board situated in the main student dining room. I recruited students from all universities, except from this third UK University, which suggested that the restrictions had prevented recruitment.

The fifth university (in SA) had the longest ethics procedure; it had the additional steps of needing a rebuttal letter, and payment was required for the ethics application. My PhD supervisor contacted the chair of the university ethics panel the evening before I was flying to SA, but this made little difference to the outcome. I was not given permission in time. I followed the processes and my application was reviewed at department level. Bell (2014) warned that some ethics committees can come across as over-zealous in their requests. Feedback from this departmental level was that my ethics application required further amendments; this included references

commonly used in SA ethics applications of which I was not aware of. The supporting professor had to step in at this point, to talk to the committee about reasonable requests and she also personally made sure that she had arranged to pay the ethics application fee. To carryout theoretical sampling, ethics permissions gave me enough time to return to universities for the 2nd time so that I could return to the field and carry out theoretical sampling.

3.21 Data Management

To maintain confidentiality and anonymity the data was stored acknowledging the data protection legislation and universities' guidance on good ethical practice (The University of Edinburgh 2014, 2016a; legisation.gov.uk 1988, 2017). Participant data was stored using encrypted pen drives; the laptop used was password protected.

Interviews were recorded on an encrypted digital recorder. These tape recordings were downloaded onto a password protected computer. For transcription of recorded interviews, a password protected Dictaphone was used, or an encrypted USB handed directly to the transcriber for transcription. Any encrypted USB pens were stored in a locked safe in a locked room.

The transcriber did not have access to information that could identify the participant's name or any personal information. Each recorded file was saved with a pseudonym and number; only I, the researcher, had the password to access these. These pseudonyms, numbers and UK or SA were used to replace the names of participants.

When in SA, all data was stored in a locked suitcase that was chained to a fixed item within the accommodation that I would be staying at. When travelling by car, data was kept in a locked car boot. When flying by plane, data was kept in a locked bag and travelled with me as hand luggage. When in the UK, data was stored in a key-coded safe, in a locked room and building. My dissertation supervisor was informed of the storage areas.

The one note computer programme was used for data analysis, and the Microsoft Word Excel programme was also password protected.

3.22 Ethical practice when carrying out the interviews

Some participants' answers were very personal to them; empathy was shown throughout the interviews by treating everyone with equal interest and respect, as this promotes the relationship between the researcher and the participant (Sprague, 2016). During the interviews I sought to respect, hear and understand what was being said (Thomas, 2017). As the research was based on personal development, it was anticipated that participant distress may occur, as they discussed the difficulties and rewards of PPD. For some participants, emotional self-reflection brought to light some new understanding about themselves. I asked permission again to confirm if I could use these accounts in my thesis that would be given as examples for these conversations were viewed to be empowering for women, as it helped them understand themselves better, confirming feminists theory to how the 'personal' interacted with the 'professional' (Scholz, 2010). For example, one woman spoke about her pride and achievement in completing her studies at an academic level that she never expected herself to be capable of. She then expressed tearfully that she had not realised that her PPD activities had been influenced by the death of her only brother.

"He was very intelligent, you know … died very suddenly at 21. So that encouragement, a lot of encouragement, has actually been put onto me". Esther 31 UK

Though she viewed herself as not as bright as him, she spoke about steadily gaining confidence in herself and had worked through modules of study and aspired to complete her degree. After this interview she wanted to go home and tell everyone, including her mum, how much her brother had influenced her PPD activities and shaped her into the person that she now is. Another woman (SA) became upset when she spoke about failing an essay at 49% when the pass mark was 50%, explaining the financial cost was devastating,

as she also was struggling to find the money to pay for submission of another essay. She was clearly upset and sought some comforting advice on this. She asked questions about how to approach this, to which after the interview had finished I responded and offered her advice and suggestions, as it would have been unfair not to have done so unless I could recommend someone else to help her, of which I did not know of anyone.

Feminists urge for attention to be focused on power relations between the researcher and participants, as this may impact on the data that is collected in that that bias can creep into interviews, as social dynamics can shape the process of data collection (Scholz, 2010; Cerwonka, 2011). Braun and Clarke (2013) assert that interviewing people who occupy societal positions of greater or lesser power than yourself, the interviewer, needs to be handled carefully. They warn that any *interviewing across difference* can be problematic; that it is better not to pretend that there are no differences between yourself and the participant, and to recognise that you cannot assume that that these *'differences shape every aspect of our lives'* Braun and Clarke (2013, p88). It was established that I held both insider and outsider roles. Feminist researchers argue that interviews by women with women are regarded as the best practice, as women can share sensitive issues together, that this two-way process is more effective than the traditional one-way process (Oakley, 1981).

However differences that I could not share were, for example, that I had not experienced poverty. However, I had gained occupational qualifications that I knew would benefit me by aiding career and pay progression; achievement of social mobility is sought by many women (Sanderson and Crompton, 1990). I chose not to ask about or refer to poverty in my questions; instead, I listened to what women said in answer to my questions and allowed women the space and time to raise the experience of being poor and being in poverty, and listened to how they viewed their PPD in aiding their social mobility. In Charlotte's case, she explained that her whole life had changed

on completing her qualification, she did it to support her children, and PPD had helped her become a "better individual". She went on to explain:

> *"I didn't get a lot of guidance in my life … because I lost my parents when I was young. We stayed with my brother … there was absolutely no, nothing. I only had schooling experience, nothing else … then I fell pregnant … I went into deep depression, I felt I was worth nothing … no money, no job."* Charlotte 9 SA

I did feel that by coming from the UK and not having experienced the SA apartheid era it placed me as what Braun and Clarke (2013) termed *"a stranger from another country*". Edwards (1990) states that the researcher should look at the differences: there was clearly a difference, between myself and the SA participants, that was greater than the similarities. I, like, Edwards (1990) did not carry any shared assumptions when I came to race and culture. This reflexivity may have assisted with the rapport between myself and the participants because it gave participants the power to educate me on their culture, the effects of poverty on SA women and the commitment that they made to engage in PPD activity. Rachel told me about the effects of the SA union strikes that resulted her being unable to work (the unions threatened staff with death should they return to work). She decided to return to university to study; she spoke about the desperation of begging for two rand on the bus stop to be able to travel to the university.

"That year I can remember when I was asking for two rand from somebody … then that person gave me two rand, and do you know how much I appreciated that two rand?" ***Rachel 20 SA***

Anita explained that she lived in the Western Cape to get a better job and education, and that rural family traditions within her home community had placed a financial burden on her.

"My mother is in Eastern Cape, I must still give money. Ja, because I am the eldest one looking after my mother". ***Anita 45 SA***

Mandisa explained that her whole family pooled their money together to pay for her studies, that this was how they did this in her culture. She explained this put pressure on her, and so she had to make sure that she completed her studies.

"I think you know if you make up your mind to do something, there's a lot of sacrifice that goes with that … there's no money, can't afford to waste it." ***Mandisa 23 SA***

The feminist approach towards interviewing is that it aims to promote an equal relationship, and rejects the hierarchical relationship that self-disclosure may be a natural part of this relationship. Braun and Clarke (2013) suggest that every researcher should have devised their strategy around personal disclosure. My strategy was that I supported empowerment and that I should also, having asked personal questions about my participants' lives, reciprocate this by answering any questions that the participants asked me. In my experience, this aided the building of a trusting relationship. So as not to become distracted from the interview guide, I told participants that I would answer any questions that they had after the interview had ceased. This, I felt, offered justice and treated participants with respect.

During interviews I used a feminist approach, expressing myself using verbal and non-verbal communication if I too had found myself in a similar situation and/or had some understanding of what the participant was saying, as this aided common connections to be made within the interview relationship (Sprague, 2016). Common questions asked by participants were on: PPD in the UK or SA, employment as a nurse in the UK, take home pay and the cost of living in the UK or SA (including poverty). Some questions from the SA women were more personal than I had expected and had some surprising effects. I was asked questions about myself, my family, and my home and money, which I answered with honesty. It was these conversations that pivoted the power balance, especially as some participants realised that they had a great deal more money left over at the end of the month than I did.

Empathy was also displayed towards me by participants from the answers that I gave to these personal questions, and concern was shown when I answered questions about accommodation and travel in SA and the energy involved, the funding and monies required for this PhD research. I had not intended to use personal disclosure as a mechanism to aid recruitment, but these conversations had influenced volunteers to come forward who told others about their interview experience. When I agreed with Grace's comments and told her that I understood what she said about feeling that you had to perform well in your studies, having been funded, she replied:

"That's why I also said, Come on guys, let's go and help Linda … because we must help each other, we never know when we are in that situation."
Grace 39 SA

3.23 Design and conduct of the interviews

Interviews were the selected method used to collect data for this would allow women to answer the questions and tell their stories allowing them to reflect on the past experiences and link this to the perceptions that they held on PPD (Bryant and Charmaz, 2011). I planned to conduct one to one interviews allowing participants a private social space for them to express their thoughts and feelings.

The interview questions acted as a guide (Appendix I) and were designed so that I could gain more knowledge and understanding about PPD and generate theory. Savin-Baden and Howell Major (2013) affirm that reliability is viewed to be when the instrument used to test and measure could produce the same results on different occasions in similar conditions. However, they point out that this view can be problematic in qualitative research, whereby a participant may not give the same answer on a different day despite using the same interview guide for every interview. The qualitative researcher needs to be aware of this when reviewing the data collection. The interview guide consisted of questions designed to ask the participants about both their

negative and positive experiences, and was developed in order to explore the emerging concepts (Keane, 2015).

On commencing this study I followed Bell's (2014) suggestion to complete a first thoughts list, which led to the creation of a topic guide on PPD (Appendix C) of which Green and Thorogood argue can assist with the preparation of what questions to ask (2009). This gave me an understanding of what knowledge I had on the subject and key areas of PPD, helping me identify areas of PPD in which there was little or no knowledge. This, in turn, led to the generation of the questions used to explore this subject (Appendix I).

Questions in the interview guide were designed so that women could express what they understood by the meaning of PPD, and to gaining understanding of where this knowledge came from. Women were encouraged to answer the questions based on their perceptions and experiences by encouraging them to reflect and talk about their social settings, practice and experience, all of which aids the construction of knowledge (Flick, 2018a). For I wanted to hear what women's knowledge was, moving away from the existing literature that could have threatened to impose on the data analysis and findings (Flick 2018a).

I established that the research would be carried out in English, acknowledging that it may not be participants' first language. This would be most likely for the SA participants, who may have been educated in another language. So, as the researcher, I checked that my questions had been understood. Those who needed the time to comprehend the questions were treated with respect and given the time to do so before, during and after the interview.

The semi-structured questions were designed so that data could be collected, yet the participant could still have some autonomy to raise issues that had not been considered or anticipated and to give them opportunity to express themselves (Braun and Clarke, 2013). The last question of the

interview had been "Do you have anything else that you would like to tell me?" This was in acknowledgement that women may have come to the interview wanting to tell me about things that they thought that I should know; if I had not asked them a question about these things, this gave them the opportunity to do so. Issues of unfair or unequal treatment were raised, all of which is important within feminist research and also assisted with my analysis, development of the categories and codes, and helped with refining them (Charmaz, 2012). Many participants wanted to know about what the results were showing, what I thought that this may be representing and contributed to meaningful discussions that aid the process of CGT.

On many occasions the questions were asked in a different order than on the interview guide, to allow the interview to flow, as some participants gave answers that had also linked to other questions, others wanted to speak more depth on what they felt was important. I made memo notes during the interviews, to keep the interview focused on the PPD (Denscombe, 2014). As the constant comparison took place, and as part of CGT process there was an expansion of questions the interview guide to assist in exploring actions, developing analytic notes and the categories were derived from these. Theoretical sampling (pp 127-128) was undertaken as I had tentative categories to develop and refine in which I kept asking myself, "what is happening here, and how does this compare to other data?" (Charmaz, 2008; 2017). Reaching theoretical data saturation in CGT includes actively searching for insights, involving participants in the exploration of the construction of theory of which is key in CGT (Keane, 2015). Hence the constant comparison from data collected from one to another led an increased number of participants from the originally intended small number of participants so that the properties of a theoretical category was saturated (Charmaz, 2008).

Data analysis began with the initial or open coding to focused and theoretical coding alongside developing questions on the arising concepts (Appendix J).

Categories that required further exploration through theoretical sampling were based on: mandatory training, sickness, working hours/overtime pay, nurses working together as a team, management and leadership, and language (SA). Theoretical memoing and the sorting of categories further identified themes: circumstances, hidden costs of PPD, strategies and techniques, rewards and benefits as topics to be explored. Lastly CGT led to aspirations and women's PPD journeys (see PPD Model figures 4, 5, and 6 pp. 270-272).

I was also aware that many of the participants were more likely to have had some success in engaging in their PPD activities, as I was recruiting those who were studying or had recently studied. Hence the exploratory question was added: "Do you think that your experiences are similar to other female nurses?" This was a way of allowing the voices of other women to be represented by the participants. Some participants told stories about their friends' and work colleagues' experiences; others passed on their own view on what other women RNs thought and experienced with regards to PPD. It was from these answers that brought me to construct theory on the differing levels of PPD engagement, and women's perceptions of employers PPD and that these two theoretical categories, formed the basis of women's perceptions towards PPD.

Creswell (2014b) argues that testing the interview questions is important in establishing if the question is effective in collecting valid data. Holloway and Galvin (2017) claim that in qualitative research studies testing questions is not always necessary, as this is a developmental process. I wrote questions that were informed by the findings of the initial literature review. I had to ensure that my questions would be understood by both SA and UK participants. I contacted the Association of South African Nurses in the UK through the RCN, to ask if anyone would volunteer to help pilot the questions, but, unfortunately, I had no volunteers. I placed an advert in the Nursing Times, which 1 SA RN replied to, but they had not been in SA for

twenty years, so that was unlikely to be helpful. I arranged to meet with a leading UK nurse researcher to outline my ideas for the study, and she gave guidance on the questions I should focus on. She advised me to cross-reference these questions against my topic guide (Appendix C). I did make contact with an RN who worked for DENOSA and kindly answered my questions about SA nursing. The next step was approaching a SA RN who was known by one of my PhD supervisors, who worked in the UK. She kindly gave feedback on the questions, making helpful references to the cultural differences of nursing in SA, and this ensured that wording used would be understood by SA participants. I took Holloway and Galvin's (2017) suggestion, and that was to test out questions in an informal manner with UK RNs that I worked with and some of whom I did not know very well. Dawson (2015) asserts that it is good to practice reading the questions, making alterations, and testing the time and flow of the interview guide. These actions helped to finalise the interview guide and prepare the researcher.

In order for the researcher to become familiar with the interview guide, to practise asking the questions and to test out the questions themselves, a pilot interview was conducted with another student. This was a useful experience, as this was carried out by telephone because I was unable to travel to meet with her on the time and date that she was available. The interview questions were understood, and appropriate answers were given, but not in the depth that I required. This brought me to recognise that telephone interviews were unsuitable, because it acted as a barrier against building a relationship with the participant. For such a personal subject, I needed to meet face-to-face with participants to be able to develop a rapport and read their verbal and non-verbal communication. In addition to this, the recording of the telephone interview was poor. For this study, I needed clear recordings to take place; I could not take the risk of me not hearing correctly or to have poor recordings. The result of this exercise was that one question was added into the interview guide, and this was to ask participants if they

thought personal and professional development were joined together or separate? I could not assume what perceptions they had, and this question was asked within the first few questions on PPD. These were aimed to be used as what Denscombe (2014) suggests as opening questions that produce a conversational flow, allowing myself and the participant to get to know each other.

Over the time of conducting this research I held many informal conversations and 'target talking' with RNs from both countries. These conversations assisted in gaining understanding, exploring the issues that were raised during and after the period of collecting and analysing the data. These actions were viewed to be a form of member checking and were essential to demonstrating rigour in this comparative research between two countries. I wanted to check and make sure that I had explored all avenues of thought to assist in my analysis of the data (Savin-Baden and Howell Major, 2013). This 'checking of understanding' varied from becoming familiar with slang or sayings used by participants, references that participants made that linked back to current and past national and local events, and references made in relation to line managers, employers and nursing regulatory bodies. This helped eliminate any 'red herrings' that were the perception of one person, and not necessarily representative of a group of participants' perceptions and experiences.

For myself, as the researcher, I needed to ensure that the thick and rich data that is a key aspect of CGT had trustworthiness, and I checked my understanding and interpretation of the data (Keane, 2015). Savin-Baden and Howell Major (2013), O'Reilly and Kiyimba (2015) all state that member checking is a strategy that can add credibility, as it allows participants to provide feedback, verification and interpretation on their interview transcript. In this study once theoretical sampling member checking commenced by having verbal conversations during and after the interviews for it was predicted that some participants would not have access to the internet to

receive electronic versions of the transcripts. Whereas the reality was that, for different reasons, some SA WRNs declined to provide their email address to receive feedback, and made it clear that they would do the interview, but no more, whereas others (both UK and SA WRNs) did not wish to provide answers to the questions posed on the data sheets. Hodges and Thomas (2010) reflect that negative past experiences with research may affect people's views of research and therefore may be unwilling trust researchers. Beinart (2001) surmises that black SA people have had a turbulent history (Nattrass, 2016), which has built a history of suspicion and mistrust between people in SA. Whereas other participants wanted to know what I was exploring, what leads I was following and confirmed the theories that I was building, some adding further analysis to assist in my theoretical coding.

After the interviews, all participants were encouraged, if they wished, to contact me with any offer any further comments. I gave my SA poster to one of the SA University's principal lecturers so that they could put it up on the wall for all participants, students and staff to view, encouraging them to consider these and to contact me with their views. Hence, this acknowledged good research practice, which is to promote autonomy and involvement in the research (Savin-Baden and Howell, 2013).

To check the credibility of the information given during the interviews I had sought to undertake conversations with WRNs in both countries within informal settings to check the information given and to develop my own understanding of some of the questions (without breaking confidentiality) that I had about what participants said or inferred at the interviews. These conversations were written in detail into my research diary, and revisited when undertaking analysis.

The results of the research was presented at conferences in SA and the UK; hence, women WRNs from the UK and SA were able to affirm to me the credibility of the research study outcomes to how they had felt that they

would benefit from the results of the study (Grey, 2018; Hatfield, 2016). For example, whilst presenting at the DENOSA SA Third Nurses Conference held in Johannesburg, SA (Hatfield, 2016) a WRN told me, having listened to me present the findings of this study, the effect it had on her. She explained it had helped her understand the situation she was in, and now she had knowledge about women's PPD she saw solutions as to how she could manage herself and her team in future PPD, despite the barriers she faced. This demonstrated that my research had given something back to SA, and the UK that would be of benefit to women RNs who wished to grow and develop, but needed knowledge to understand the dynamics of PPD in women's lives, and to seek support to navigate around or through the difficulties of which the PPD Model could be used as a tool by RNs as a means of problem solving and planning future PPD (see Figures 4, 5, and 6).

Rigour is defined by Moule, Aveyard and Goodman (217, p213) as *'the accuracy and consistency of a research design that gives a measure of its quality'*. O'Reilly and Kiyimba (2015) argue if there is no rigour in research it is worthless, as without a meticulous approach towards the research process, the research may not discover any versions of truth that they aim to investigate in their research and its claims could be challenged (Savin-Baden and Howell Major, 2013). Silverman (2014) asserts that by outlining the details of the research process this aids transparency of the rigour in research. O'Reilly and Kiyimba (2015) assert that reliability and validity are the main focus of qualitative research that uses an interpretive approach. Golafshani (2003) argues that though validity and reliability is commonly used in qualitative research they are rooted from positivist or scientific paradigms and used often in quantitative research, that to use these terms in we need to understand that these terms differ within qualitative research.

Bryman (2016) defines validity as questioning if a set of indicators has been set to measure a concept, and then to examine to see to if this has been achieved. O'Reilly & Kiyimba (2015) suggest that, for qualitative research, it

is important that you use an appropriate means of measurement. Golafshani (2003) asserts that in qualitative research it is the researcher that is the instrument that acts to measure, thus credibility is based on the knowledge and ability of the researcher. Golafshani (2003, p600) concludes that

> *'although reliability and validity are treated separately in quantitative studies, these terms are not viewed separately in qualitative research. Instead, terminology that encompasses both, such as a credibility, transferability and trustworthiness is used'* for it is these that act as criteria that is essential to qualitative research (Lincoln and Guba, 1985).

Creswell (2014b) argues that reflexivity plays an important part, that the research needs to acknowledge any bias that took place. When planning this study, at the beginning I had to ask myself if there were any conflicts of interest, of which I felt I had none. However, I recognised that my personal interests were that being a woman, nurse and academic gave me the opportunity to connect with my participants, but equally, I had to be aware if I behaved in such a way, that this could have an effect on the way that I had collected, interpreted the data and results. Dietsch (2014) argued that in comparative research it is easy to make judgements about the culture that you do not live in, without looking at your own culture. Hence, collecting and undertaking analysis by alternating data collection periods between the two countries helped with examining both countries culture in a less biased way.

3.24 Data analysis

Lincoln and Guba (1994) argued that an audit trail of research can demonstrate that research is credible and dependable. It acts to confirm the analytical processes involved, but at the same time it needs to be recognised that the trail of decision-making may not be clearly understood without the researcher's dialogue, as it is what Moule *et al.* 2017, p183) argue it is the researcher's own *'immersion in the field and data that brings uniqueness to*

the interpretation'. CGT embraces the researcher's involvement in the grinding of the theory.

Higginbottom's (2014) diagram demonstrates the process of CGT and the process of coding that was followed to lead to the construction of the categories in this study.

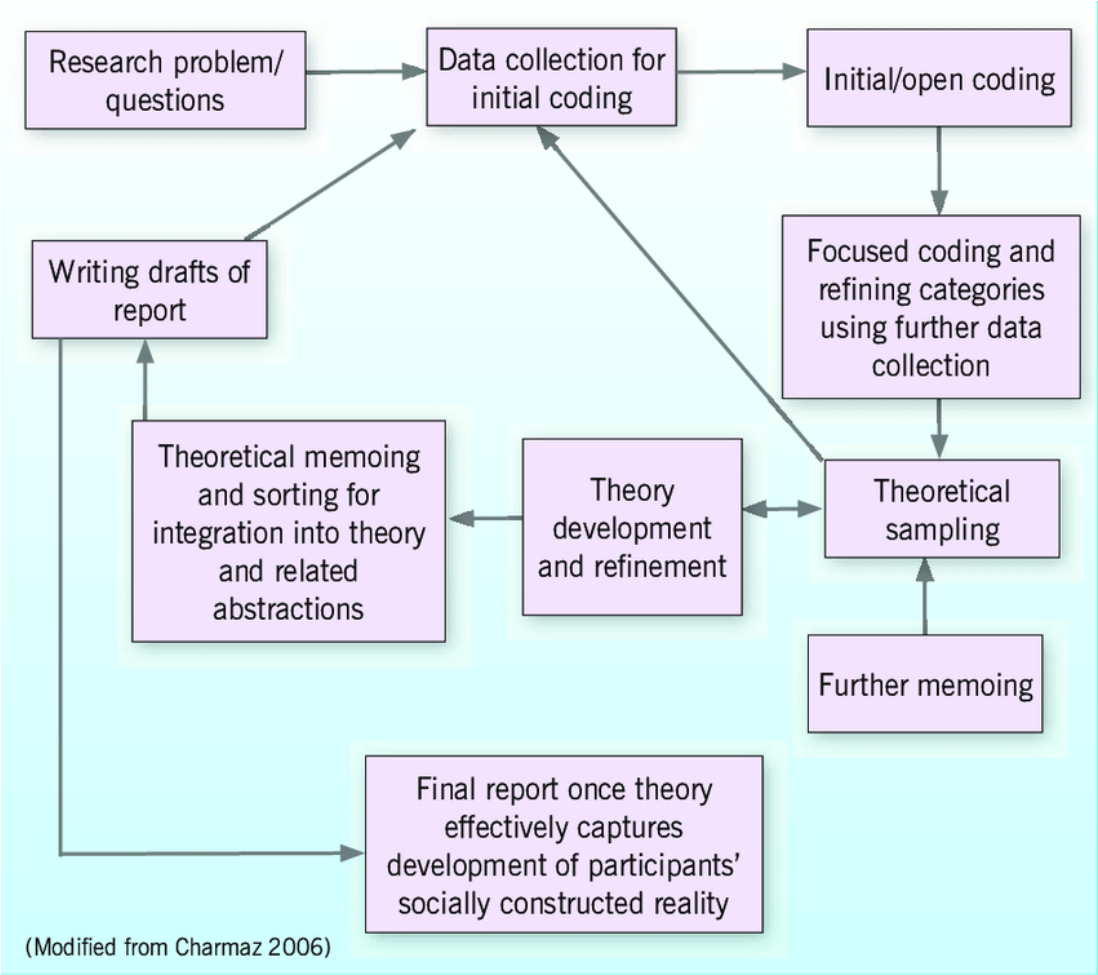

Figure 3 Diagrammatic explanation of CGT, Higginbottom (2014, p11)

The UK interviews were conducted first and initial coding commenced. Then interviews from the first SA trip were undertaken. Focused coding subsequently took place followed by theoretical sampling with a return to the field to conduct further UK and SA interviews, finishing with one more UK interview in order to reach a point of theoretical data saturation. Finally theory

development, theoretical memoing, and writing drafts of the report was completed. The reading of interview data and the process of analysis and coding started during the first stage of UK interviews, as I was more familiar with the issues surrounding PPD in the UK than in SA. I wanted to see if the data from the interviews had been noted already in the topic guide, and if there were any surprises. Secondly, I wanted to be sure before I travelled to SA that I had some knowledge of the results; should participants in SA ask about any differences found from the UK interviews, I would have already started my comparisons. Additionally I could explore concepts raised in the initial coding from the first set of UK interviews in the SA interviews.

Many participants completed the short questionnaire (DDS) whilst in the interview room, before the interview took place. Some discussion took place with participants about the questions asked on the questionnaire before the interviews; hence, this assisted with getting many of the questions answered correctly, though participants were reminded that they did not have to answer any questions if they did not want to. I started making notes at this point, and continued to leave my Dictaphone on, as some participants went on to make further comments after the main part of the interview had ceased (participants were aware that the recording was continuing).

The information from the short answer questionnaires that acted as the DDS, was transferred onto an Excel spreadsheet that was password protected and was referred to when further analysis was needed on the context in which the quotes were made. When examining the characteristics of participants in the sample for this study, the aim was to have women from a range of backgrounds and experiences who could offer differing insights on PPD.

Transcriptions were checked by myself, who listened to the recordings to see if any discrepancies had occurred. Transcripts were read line by line. Direct quotations remained intact or they were split into smaller segments, ensuring at the same time that the quotes remained with the context that they referred

to, and could not be interpreted differently or used inappropriately to support any false claims. This kept trustworthiness and credibility within the research by providing evidence that supported the research claims (O'Reilly and Kiyimba, 2015). The verbatim quotations that were identified with having meanings were entered into a password protected One Note, with one file for each participant; a number and country of the participants formed part of the name for the file. Quotations and key words were copied and pasted from the transcripts and saved. In addition to this, a document of quotes[14] was created and used alongside the coding chart was also created, this stated the category and what quotes from WRNs from SA/UK supported the category. Though time-consuming, this gave me the advantage of being able to find quotes and key words easily and undertake simple checks on how many participants, and from which country made references (the One note files, quote document and the coding chart were continuously referred to when undertaking the analysis and writing up the findings[15]). At the same time, I began to analyse the data through the use of memos and analytic notes; key words with brief quotes were placed onto several flip charts that helped me identify repetition by linking and creating groups of data through the use of spider diagrams and conceptual mapping. All of these were then transferred

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[14] This is a comparative study, it used a quantitative approach (for most cross-cultural comparative studies a quantitative approach using statistical analysis is used (Ember and Ember, 2009). The quote document was created so I could see clearly what had been said by whom. Loose descriptions of numbers of participants have been provided for example; where a few participants is whereby no more than three participants from each country had made statements with regards to the issue/topic. The minority and majority and other phrases were used to describe and compare the findings of each country.

[15] Where possible both SA and UK quotes have been provided, however Creswell (2007 p182-182) discusses the differing uses of quotes within a qualitative study results, summarising many types of quotes that are used for differing purposes. From providing short and sharp quotes that make clear statements, paragraph quotes and those that *'convey more complex understandings,* Creswell (2007 p182-182). For this qualitative study it was decided to select the use of different quotes that illustrated the rich and thick data that supported the theory derived from the study. Quotes that were "thin" were acknowledged within the analysis of data, but not used as examples within the findings of this study, Creswell (2007).

to my coding chart (Charmaz, 2016). During this process, I recorded my own reflections and understanding of the quotations in my research diary.

The use of the CGT resulted in constant comparison taking place throughout the research process. The collection of rich thick data supported internal validation; this was referred to when working on the coding of data from open initial coding to focused coding, (Charmaz, 2014). Analysis was undertaken whilst "grounding the theory", memo writing, constant comparison and re-visiting the transcriptions, to see if there were similarities of any codes, identifying if there were any relationships between them. I took Charmaz's (2014) advice to undertake in-vivo coding whereby some codes were named using the specific wording that the participants described, for example "tick box joke", "professional jealousy", "not academic", "one off", "having a go", "tidy house-tidy mind" and the "wrong time-right time". Relating back to the DDS information helped place the context that the women's quotations referred to, for example a newly qualified nurse, or the speciality that they worked in (though not all women answered the questions).

A considerable amount of time was spent in undertaking constant comparison, reviewing and ordering categories that had been constructed from my coding chart and, to ensure that I was clear in my analysis of the categories (Creswell, 2014b), and confident that the ordering of the themes, subthemes, and categories within them, identified within my research findings and conclusions were what was set out to be identified and reflected the data. Any questions raised during this process with reference to the genuine connections between categories led to revision of the transcripts, my research notes from the interview, my reflexive research diary, and conversations and questions with the participants. Rapley (2017) argues that undergoing this process of coding and categorising along with adding new data encourages conceptual development, as the researcher adds or rejects analytical ideas.

Bryman (2016) argues that memo writing aids the researcher's analysis by serving as reminders to prompt the researcher when undertaking analysis of what participants said and to note the researcher's reflections. My memo notes were in the form key words, quotations, questions and analytical notes. These were placed on large flip charts placed around the room, and on sticky note pads. I then re-read the notes I had made about the interview and my other notes from my research diaries. For Fuss and Ness (2015, p1411) state that there are several advantages of this is that it promotes exploration of the *'different levels and perspectives'*. Mind mapping of the key findings was placed on the flip charts. Ordering and re-ordering took place, along with reviewing the transcripts to double check my own understanding and ensuring that there was rigour in my research.

Hence, I found myself in agreement with Silverman (2011), who argued that prior knowledge was viewed to hinder the development of grounded themes. Braun and Clarke (2013) postulate that the researcher needs to give themselves enough time to get it wrong, realise that they have got it wrong, and to start again. This constant review and comparison aided the process of CGT.

I had looked at the electronic computer analysis packages, and undertaken training and decided that these were overrated in being that you had to have internet access to use them. I often did not have internet access (SA is challenging at times, as well as living in a rural area in the UK). The uploading of the information resulted in distancing the researcher from the data. As a feminist comparing two countries, I was concerned about the effect it would have on my analysis and findings. Lastly, I reflected on the experience of others who told of losing all of their work, and having to start again, therefore I declined to use them. I found myself in agreement with Thomas (2017, p244), who questioned what is wrong with '*pen, paper and a brain'.* The advantage of having this coding chart was that I could access this at any time, it was useful to have at conferences and presentations if I was

questioned in depth by others at conferences. Rapley (2017) argues that creating your own coding schema can give you confidence, which it did, and it acted as proof that I had not just made my own assumptions but had undertaken the process of grounding the data. Which produced a clear outcome, identifying new data, codes, categories, and the interrelationships between each theme, its sub-themes within the theme and the categories.

Dawson (2015) argues that the qualitative data process in a very personal process, I used pens and flip charts, to draw diagrams and jot down key quotes and thoughts to guide me through the process.

Bryant and Charmaz (2011) propose that academic credibility is achieved through the use of at least two types of sequential coding: initial coding and then focused coding was undertaken along with further exploration on the data collected to answer the exploratory questions that were raised in order explore analytic questions. I had looked at ways to manage this process and chose to create a coding chart to assist me in this process. To undertake analysis of the data, and grounding of the data into codes and categories (Millar and Birch 2012). I used a template chart set out by Buetow's (2010) saliency analysis coding chart adapting it for my own use in CGT and drew upon principles from Ember and Ember's (2009) book on Cross-Cultural Research Methods. Below is the list of questions that I used in my coding chart. I used the two questions that Buetow posed in his chart:

(1) If the code was highly or not highly important?
(2) If there was recurrence or no recurrence.

Then I added in the following headings that were important to my research design:

The name of the code and if it was created originally from the UK or SA;
Other codes it linked with directly and indirectly;

Questioning could there be a comparison between UK and SA? No, yes, maybe and if so how? (6) If I thought that this was new knowledge – if so, list these areas

(7) Comments in relation to literature review, variables, influencing factors, culture, critique, and feminist viewpoints. The new knowledge was divided into if I thought it was definitely new knowledge, and new knowledge in that it added different aspects to issues that I was aware of but dependent on the literature review findings conducted after the coding to confirm these.

At the end of this eighty-page document I made further notes on the critique and questions, when, Dawson (2015) argues, it is important to make notes of the meanings. I then summarised what each code was about. Hence, this chart had two purposes. Firstly, to assist with the recording and analysis of the data, and secondly, to use as a reference chart for topics that had to be raised and/or explored within the literature review that would take place after the data had been grounded, thirdly to make analytic notes, see the processes and to identify important processes as the data collection and coding became more focused (Charmaz, 2012). Using Buetow's (2010) questions helped a little with the analysis of the codes and the development of the categories. What it did achieve was sieving out the less important codes and establishing the relationships that the codes had with each other which was essential in this comparative study, before looking to see which formed into a category. Being a comparative study, it raised the importance to question what was and what was not comparable between the two countries e.g. differences in PPD policy and CPD training days of which effected the answers that were given.

Bowling (2014) states that for inductive analysis to take place, the research needs to build theory inductively from their observations, before general statements and theory can be derived. Using an A3 flip chart I started to draw a number of spider diagrams (Keane, 2014) and undertook

diagramming to ascertain what the category consisted of and the variations between them and the relationships between categories. This ongoing process commenced from conducting the first UK interviews, and I continuously returned to this process and completed this process after the last interview. It helped lead me to mapping and the ordering and re-ordering of categories and then establishing the core theme and its sub-themes. This then led to identification of the remaining 3 main themes and sub-themes, that were developed from the core theme. These actions helped me construct the data along with writing analytical memos, assisting in creating tentative ideas, and to examine these further (Charmaz, 2006). What was apparent was that in all the themes – the core theme 1 and the 3 main themes, there was some interaction of the data. The data had a differing relationship within each theme that they were situated in, this was because of the differing aspects that some categories represented, bringing me to agree with Charmaz and Mitchell's (2002) claims that using CGT creates a streamlining of the data that, in turn, aids theoretical analysis.

The theoretical analysis was achieved by using a coding chart by which codes and then categories were identified, these categories offered the detail required to unravel the complexities of women RN's PPD. These categories grouped themselves to form themes and sub-themes. When undertaking the coding and identification of data it became apparent that some data appeared within more than one theme, sometimes having more influence on one theme, than on another. It had been important to do this, for them to represent the meanings of the data that applied to the theme. Categories have been clearly signposted within these results by appearing at the start of each section.

The core theme 1 and the three main themes that were identified have come from having undertaken the analysis of the data, which in turn had driven the need to create the emerging PPD Model to demonstrate how each theme is

interdependent on each other and exposes the hidden dynamics of this process. The PPD Model acts as a basis for further theoretical development.

These actions resulted in the identification of the core theme 1 and three main themes. Alongside these themes was the generation of the emerging PPD Model (see Chapter 6:, Figure 6) which provided a representation of the interaction between themes. It became apparent that there was a blurring between the different perceptions and experiences of PPD. Deeper exploration of these within the interviews, and the meetings that I had with other RNs from both countries led to understanding why this was so, the theory behind it and the creation of the PPD Model. What affected the participant's engagement and success of PPD, and what influenced PPD activities, helped identify the patterns that are demonstrated in the PPD Model. Braun and Clarke (2013) state that analysis of data and emerging theories should be based on representing and answering the research question. Bryman (2016) alleges the researcher should reflect on this process and consider if they have made a theoretical contribution to the literature on the topic of study. Abbott and Wallace (1990) argue that for research to be beneficial to women it needs to be easily understood by women. The PPD Model and theory achieves both of these goals. Presentations of the PPD Model and the findings were given in the UK and SA, where I was able to observe that women RNs could understand the theory, and that many agreed with the perceptions and experiences of RNs' PPD, including 1 SA woman who had listened to my presentation of these findings at a UK conference (Hatfield, 2016).

It was paramount to this research to take into account the variations between the two countries and the extent to which it may have affected the collection and analysis of the data (Ember and Ember, 2009). This research design added to the rigour and transferability in that the results could be made more widely applicable to women's perceptions and experiences of PPD (Ember and Ember, 2009; Lincoln and Guba, 1994).

To conclude the rationale for the research design, methodology and the methods used have been discussed. The analytical routes taken have been explained within this thesis; the evidence accounts for the credibility of the findings (Lewis *et al.* 2013) and providing a clear audit trail as to how the research was conducted demonstrates rigour and trustworthiness (O'Reilly and Kiyimba, 2015). In this qualitative research, it has been demonstrated that the use of CGT and reflexivity was appropriate for the research that focused on women RNs. The feminist approach influenced the study by placing gender and women as paramount.

Chapter 4: **Findings**

4.1 Introduction to the Findings

One core and three main themes evolved from the categories derived from the Constructivist Grounded Theory (CGT) (the rationale for decisions made around processes used and the presentation of results, have been discussed within Chapter 3:. These themes identified what WRNs perceived and experienced when undertaking PPD: the constraints and barriers, and what they perceived and experienced as the rewards and benefits of PPD. Chapter 4: focuses on the core theme Women's perceptions, experiences, and the rewards of personal and professional development, which links directly to the three main themes (figures 4 and 5). Chapter 5: focuses on the three main themes 2, 3, and 4, with the PPD Model presented in the Discussion Chapter 6 (Figure 6). The similarities between each country are identified at the beginning of each theme, with any differences between the two countries highlighted in bold throughout. Issues that only relate to women within one country and not the other will not be compared. Further comparisons between each country are placed at the end of this chapter.

Each theme has sub-theme/s set out in Table 8 below, the sub-themes consist of categories. Direct quotations, distinguished by participant name, number and country (SA or UK) are presented to support each category and to illustrate their meaning.

1st Core Theme:	Women's perceptions, experiences, benefits and the rewards of personal and professional development	Sub-themes: • Perceptions, • Experiences, • Benefits and Rewards
2nd Main Theme:	Women's perceptions and experiences of engagement, aspirations and circumstances that can influence and/or limit PPD	Sub-themes: • Perceptions of Employer-led PPD, • Women's own perceptions of Nurse led PPD, • Aspirations and Circumstances.
3rd Main Theme:	The hidden costs of PPD activities and the Strategies and Techniques that women used to overcome the difficulties	Sub-themes: • Costs of PPD, • Strategies and techniques that women used to overcome the difficulties.
4th Main Theme:	Women's PPD journeys	Sub-themes: • The pace of the PPD journey, • Women controlling and managing their PPD journeys, • Unplanned and planned career approaches.

Table 8 Core Theme and 3 main themes

4.2 Core Theme 1: Perceptions, experiences, benefits and rewards

The core theme has three sub-themes: perceptions, experiences, and the benefits and rewards of PPD. Main themes 2, 3, and 4 link directly to this core theme 1.

Core theme 1 starts with the WRNs perceptions about PPD, how women perceive and define PPD and what their experiences have been in relation to undertaking PPD activities. Then I describe what they perceived as the benefits and rewards of PPD, a crucial sub-theme to answer the research question.

4.2.1 Perceptions- 1st sub-theme

The sub-themes are derived from categories which identify the key areas of women's perceptions and personal theories and ideas around PPD, beginning with the exploration of the definitions of: personal and professional development, personal development, and professional development, and confirming whether PPD was perceived to be separate or joined together. I also explore women's reflections on the extent to which professional development influenced personal and academic development.

In respect of a definition of personal and professional development: **UK and SA** WRNs held a general perception about what personal and professional development meant. It was that nurses needed "to grow" (a **SA** term, Richards and Potgieter, 2010) and to continue to develop and learn.

Women from both countries perceived that PPD is having self-awareness, keeping up-to date in the speciality that they work in, and with the latest policies and procedures in the organisation that they work for.

"To upgrade yourself, your knowledge, like to acquire more knowledge by studying further". Akua 6 SA

"Continuing our education throughout our career, building our education. It's keeping on top of current practices... making sure we are up to date".

Danielle 46 UK*"Growing as a person".* Esona 14 SA

Personal development: WRNs from **both countries** generally viewed personal development as related to 'soft skills'. Soft skills were often perceived by **SA** women as relating to the inter-personal skills that they used within their jobs as well as their lives outside of work. For both **SA and UK** women gaining the confidence and assertiveness to ask questions and challenge decisions were also viewed as personal development. Career development was often cited as personal to the individual[16].

"Discipline, ne. More tolerant … patience … maturity, motivation". Deborah 9 SA

"Time management must be another thing and the listening skills". Sisa 43 SA

"Personal skills, and relating to people, and just kind of perceptiveness". Julie 44 SA

Professional development: **Both UK and SA** women commented on what they perceived as the shift from traditional professional development, which was in the form of qualifying as an RN and gaining experience, and perhaps undertaking a specialist nursing qualification at a later stage, to the "modern way of today" of which professional development consists therefore of qualifying as an RN with an academic qualification, gaining experience and undertaking more qualifications and courses through PPD activities. Stating that PPD is no longer just about having the information required to carry out the daily nursing job, and completing mandatory/in-service training, it is now perceived as the need to keep up to date with the constant changes happening in the specialist areas that nurses work in. Women in both

[16] Further evidence can be found under the sub-theme benefits and rewards 4.3.3.

countries had perceived and a few experienced, that PPD is about having self-awareness. They acknowledged that "if you are becoming stagnant and/or your knowledge or skills are becoming outdated", then the individual RN needs to address this by taking action to engage in further PPD activities to update themselves about the changes happening in healthcare. Regular PPD engagement is needed to be able to provide safe and up-to-date nursing care as the following comments suggest.

"You have to keep up to date with what's going on or else you'll fall behind and become dangerous in your practice". April 1 UK

"So that you don't stagnate, and you don't become obsolete in your work. You must always stay abreast with technology and with trends and with research and all new practices". Zoleka 37 SA

Personal and Professional Development, separate or joined together?: The majority of **UK and SA** women perceived PPD to be linked, joined together or merging at certain points. This resulted in the boundaries of development activities being carried out within paid work, which spilt over into women's private lives and vice versa.

"I do believe that the two do go together and that the one can influence the other because when we develop personally then we can and want to develop more professionally". Lumka 22 SA

N**o SA** nurses commented PPD consisted of mainly professional development and not so much personal development or vice versa. However a few nurses perceived PPD as being very separate, but that the personal and professional linked at different stages or points.

> *"I think there's a difference. Personal development can be how you grow as a person…But professional development is growing into your profession, like going from one stage to another".* Pam 13 SA
>
> *"It depends on the individual … what you prioritise as your personal developmental goals, will determine your professional development. That's the ways that I view it*

> *and it's reflected in my life story… wanted hours that meant I didn't have to do shift work".* Angela 12 SA

One **SA** RN explained that even though the personal and professional were seen as a whole, she said that they should be viewed separately, and that some of her personal development needs were important, and not necessarily linked to professional development. Another nurse argued that they were separate but related because the development of some nursing skills/characteristics affected the personal as well as the professional.

> *"I think that they are as a whole. How you live it out, is, a whole, but I think it is useful if you view them as separately… Because if you know what your personal goals are, you are able to engineer or direct your professional goals, or your professional development*". Angela 12 SA

Three **UK** women perceived that the personal and professional were joined together, whereas the majority of the **UK** women felt that they were separate. Three **SA** RNs also felt that they were separate. PPD was viewed as being separate, and not joined together by the **UK and SA** women for the same reason, namely that professional development was perceived to be employer-led, not led by nurses as individuals. WRNs felt they had little control over their PPD: they received little support from their employers to develop themselves on subject topics that they personally wished to study. They also spoke of receiving little support for study that would enable them to achieve an academic qualification.

"My perception is the fact that it's my own personal journey and how I've developed in my nursing career". Dawn 32 UK

Professional Development with transferable knowledge and skills to personal development: A few women from **both countries** linked professional development positively to transferable knowledge and skills in personal development: IT skills, soft skills (interpersonal skills), critical thinking skills and confidence were often given as examples of this.

"What I did get a reward from, prioritising better, prioritising my time, time management". May 3 UK

Academic development gained from professional development activities: Both **UK and SA** WRNs believed that they had developed their academic skills and knowledge. The development of academic knowledge and skills was mostly due to having been initiated through professional development activities although for several women, they had personally wanted to develop these academic skills and knowledge anyway. They had identified that professional development activities would help them in developing these skills, and embraced having the opportunity to do so. One nurse from the **UK** identified PPD as being an activity that was funded by work.

"The development through work, that's funded through work … it is personal development but it has that professional element for them to fund it and approve it through work". Joanne 26 UK

Women recognised the need to keep up to date with the changes happening in the workplace in order to be able to carry out their jobs safely. Criteria for job specifications may have changed, in that some now require an RN to have completed a named course with the stated level of academic qualification. Without the academic qualification they would not be able to apply. Restructuring, down grading and re-application of jobs is now commonplace in the **UK.** If nurses do not have evidence of recent PPD activities, then they lessen the chances of being successful in these job applications or when they have to re-apply for interviews conducted for re-structuring purposes.

> *"I think it's something that we all need to do to be able to keep up to date with everything and I think it's about your own career development as well – it depends where you want to go... I think it's important for everybody to keep up to date with things and in the NHS things are changing so much all the time so I think it's really important for everybody really*". Helen 33 UK

To summarise this 1st sub-theme on perceptions, the results were that the general perception as to what personal and professional development meant was that nurses needed "to grow" (a SA term) and to continue to develop and learn. WRNs from **both countries** perceived that PPD is having self-awareness keeping up-to date in the specialty that they work in, and with the latest policies and procedures in the organisation that they work for. Several women from **both countries** felt that there was a division between what was personal and what was professional, that personal development included career development and aspirations and that personal and professional development joined together at certain points or stages within WRN's working lives. Only one **UK** woman stated that PPD was required to meet the NMC PREP standards.

4.2.2 Experiences – 2nd sub-theme

The categories in this 2nd sub-theme are mainly about women's jobs as RNs and their employing organisation, and the support that employers give, or do not give for women's PPD activities. Also involved is lack of funding, time, space and support within the work environment and outside the work environment, the physical and emotional exhaustion of studying and working at the same time, and having to 'phone in sick' because of feeling unwell (many such women had not been given any paid time for study leave).

The remaining categories in this 2nd sub-theme focus on the experiences of WRNs who have come up against the challenges of obtaining qualifications that are essential requirements for some jobs: management jobs in SA and jobs at band 6 in the UK. The experiences and perceptions that **SA** RNs of hold with regards to whether private or public employers offer the best opportunities for PPD are also considered, and finally a cultural issue of **SA** white women experiencing difficulties in employability due to the "colour of

their skin"[17]. These findings reveal the true extent of the difficulties that women from **both SA and the UK** have had in undertaking PPD journeys, and for the majority of WRNs in this study, the minimal support they have received.

Core activities (in-service/mandatory training): Women's perception was that it is necessary to do training to be up to date with the employing organisations' standard procedures.

It became apparent that there was a **difference between the UK and SA** experiences of core training. **SA** WRNs experiences of core training were when RN's had face to face taught training with other staff, and they felt that they learnt from these sessions.

"As a nurse it's important to keep up to date with what's going on, with change, just about every day in hospital, we don't always agree with what goes on but we have to follow the rules and regulations". April 1 UK

Several **SA** women working in SA NHS hospital environments said they found these in-service days to be useful: they learnt a great deal from other professionals as well as from those who were facilitating the discussion and teaching. Their line managers were supportive and ensured that in-service days were booked in the diary so that they could attend. The hospitals also arranged for transport to attend the in-service days.

"We learn a lot, like communication skills, to resolve the conflict, those things. To be part of the decision making, not only disciplinary codes, those in-service courses is helping a lot". Anita 45 SA

[17] This is in relation to the SA Black Economic Empowerment (BEE) policy that discriminates against white women (Appendix A).

SA WRNs working in rural areas had different experiences. They said that they struggled to attend the in-service days, due to short staffing and the lack of transport and time needed to get to the training venue.

WRNs in the **UK** had different experiences and perceptions. It was apparent that some did not believe that all of the core trainings that they were required to undertake, were all necessary and that women preferred the face to face training, and disliked the online training, that the quality of learning was much less, and that they did not enjoy this style of training.

"The district levels they don't get those kind of things but now I can see they are trying to invite somebody because they use like basic life support… short staffed and over-crowded". Sisa 43 SA

> *"It's boring … As long as you know Trust policies and protocols this is what we do with this, this is what we do with that. It's all just ticking boxes".*
>
> Eleanor 30 UK

"I think it's more beneficial to go somewhere to a taught session because you're out of the work environment and you can focus on it whereas people are trying to fit it in between appointments and it doesn't get given the time that it perhaps needs. I think everyone thinks that the online training is a bit of a tick box joke". Karen 35 UK

UK women stated that there was a struggle for managers to release nurses from the workplace, and this is why online training had occurred. However this had not helped to overcome the problem of short staffing. Women were expected to undertake online training within paid working hours, but many women ended up carrying out online trainings in their own time outside of their paid working hours because there was not enough time in the working day. Those that did the online trainings had to undertake these whilst being surrounded by a busy working environment. One woman explained that she disliked her line manager's approach towards getting her staff to complete her online mandatory updates. Therefore, she chose to carry them out in her own time, using the hospital's library because the online programmes often did not work very well at home. Her computer skills did not equip her to

understand how to use and access the online courses. By doing this in her own time during the winter months and in a comfortable environment she felt that she took control of this, rather than her line manager controlling her and having the power to tell her to do these online trainings.

"I've kind of got into the mode of studying I like to get them done and then they're not hanging over you for the whole of the year … So for peace of mind as well as a peaceful environment it's best to do it here". April 1 UK

The **UK** women's perception was that it is necessary to do training to be up to date with the organisations' standard procedures (often termed as mandatory training that is applicable to all staff, and not based on teaching or learning nursing care within the specialist areas RNs were working in). Overall, the experience that women from **both countries** had was that taught sessions were much better than doing the online sessions, but they often struggled to attend these due to low staffing levels. Employers, **more so UK than SA**, now run many of these core trainings as on-line computer courses primarily perceived to overcome the issue of staffing levels. Many women from **both countries** had to claim "time owing" hours, because they were unable to do these online courses during their working hours, however this was more common with **UK WRNs** depending on the area where they worked. The majority of **UK women** found that often the content within core training was repeated from the previous year's training, and they argued that they did not learn anything new, except for very minor updates. Hence the experience of doing **UK** mandatory training was more negatively perceived than the majority of **SA** WRNs whom had positive experiences of core training.

WRNs in the **UK and SA** understood the importance of undertaking mandatory training. They found taught sessions more beneficial and enjoyable than online sessions. **UK women and SA** RNs working in rural areas struggled to be released from the work environment to attend mandatory sessions. Online training in the **UK** was regarded as a "tick box

joke", with the emphasis on getting it completed in as short a time as possible. Many WRNs had to undertake the online training outside of working hours in order to be able to complete these training sessions, taking time back at a later date.

The majority of women said there was no time as they were too busy and did not have enough staff on shifts in order for in-house teaching sessions to be organised and held on the wards, as experienced in the past. Two **SA** RNs stated they had received regular teaching on the wards. This allowed them to develop their nursing knowledge and skills within the speciality they were working in.

> *"We had an amazing, amazing unit manager, wow she was an advocate for teaching and learning … she came in with writing and reading material… We'd go through it again and test our knowledge… that morning the whole group would be there, so you'd have that discussion around the topic… what do you think in our unit we need to change, and our practice".* Mandisa 23 SA

To summarise: many of the **WRNs from both countries** were not given opportunities to experience and/or receive teaching or learning activities within their work area that could have helped them to develop knowledge and skills within the specialist areas where they worked. There was no mention from women from either country on experiences of other informal PPD activities such as mentoring, shadowing or supervision. This indicates that RNs have become more reliant on engaging with formal courses to develop their knowledge and skills, and less so on informal PPD activities in the workplace.

Several women in **both countries** were lucky to have employers who were willing to find funding, time and resources for them to undertake PPD activities. **SA WRNs continuously** debated whether public or private

employers were best in offering PPD opportunities[18]. It appeared that private employers offered more opportunities for informal PPD developing their job roles within the workplace, whereas NHS employers offered more funding and time to undertake formal PPD.

"Private do not offer study … the government is better". Khuhula 19 SA

Cebesia who worked for a private employer argued the opposite.

"You always had an opportunity to develop yourself further, you know … I'm forever grateful". *Cebisa 9 SA*

Private employers gave bonuses to staff for undertaking PPD activities and rewarding good practice.

"They evaluate you during the year, unknowingly … you are being watched … they give you a bonus". Wazini 40 SA.

Several WRNs in **both countries** were supported by their employers to obtain qualifications that were required in the service. In the **UK** this was the mentorship module (recognised by the NMC and often required for jobs banded at grade 6), and for some the advanced practice qualification. However for others they were not so lucky, and had to fund themselves to obtain these qualifications. In **SA** the nursing administration qualification (recognised by SANC) was another qualification that was sought after, for it was required for higher paid jobs in management.

> *"We need to do – we get told we have to do mentorship courses. When we're newly qualified they say you've got to identify goals for the future and the goal from the organisation is always mentorship and then they'll offer you other courses but you don't have to take any other*

[18] No UK participants debated this issue, all UK participants were working for the NHS, only a few had worked for private employers. The UK only has a small number of private healthcare employers in comparison to SA so this may be why SA WRNs raised this in the interviews (Appendix A).

> *courses but they strongly advise and encourage you to do mentorship".* Karen 35 UK

Whereas other WRNs from **both countries** viewed employers as expecting RNs to undertake PPD, for many this was without much support. This lack of support from employers for PPD activities was seen to be having an effect on women's development. These struggles for support were observed by other women colleagues, which in turn acted as a caution to them not to undertake PPD. Some women, from their observation of other's struggles, had decided not to approach employers for support as they perceived that the answer would be "NO!" For some they decided not to ask, and to not carry out more PPD. Some women found it difficult to complete application forms, and a few did not believe that their application would be successful, although a few tried. Managers warned that there were only small budgets for a large number of applications, and that this resulted in less opportunity to receive financial support – and therefore less opportunity to start or continue with their PPD activities. The women found their line managers' warnings off-putting and discouraging.

"My manager made it very clear, at the very beginning, that if I did my Masters it would be in my own time so I didn't expect any more than that". Eleanor 30 UK

A total of three women from **both countries** were able to receive support and funding by undergoing an application process to obtain funding from their employers. For example, Danielle worked in a smaller hospital trust.

> *"Yeah we have the CPD options within the Trust so it's really, really good actually because they do fund quite a lot of the courses that we want to do".* Danielle 46 UK

For several women from **both countries** they took the other direction, which was to self-fund, or seek fragmented funding. For others they could only take the opportunity of fragmented funding and had no finances to self-fund. They viewed their employer as being non-supportive and, in some respect, as

controlling their development. None of the women in the study had attempted to apply for funding outside of their employing organisation such as charities, bursaries, grants.

> *"She was paying in her own time to get the qualifications to top up to the degree so that she could apply for a band 6 … I thought that was really unfair*

that they weren't offering to be supportive". Karen 35 UKFragmented funding: WRNs from **both countries** were found to be no longer receiving full funding but rather now experiencing fragmented funding for their PPD. As a result, several women had used different approaches towards gaining support to be able to complete their PPD. Some women had decided to self-fund, the advantage being they could study at their own pace, and complete within their planned time period. For others who were undertaking academic studies, they had studied for a lower qualification that had funding attached instead of studying for a higher - level qualification which they would have preferred. But they could not afford to self-fund. For the few women who had experienced the negative impact of waiting for funding, the result was they did not complete their academic studies within the set- time period stipulated by the academic institution resulting in them not obtaining their qualifications.

Supporting nurses in different ways, and not supporting nurses: some line managers offered and gave support by agreeing to support their staff and ensuring that they had funding.

"My manager said, he would continue to support me if I applied for courses funding wise". Karen 35 UK

But even some of these line managers experienced barriers, with the employing organisation having put in place additional rules which were experienced by WRNs as obstructing their development. Some of these rules were written down, but many were hidden, with WRNs being given verbal explanation of these "hidden rules" that they had never heard of - with no policy or procedures to back them up.

> *"There is a policy that says even if you don't have study leave, your employer they are obliged… to give permission … I didn't even write a letter to inform them that I'm studying, because I thought for me why must I inform them, because I don't have study leave".* Akua 6 SA

> *"I've decided – now I've had enough, I'm going to do this. I can't wait for study leave that's going to be granted here, over so many years. Or when they decide … I felt like they were in control of me".* Charlotte 9 SA

Embracing PPD rejected by service needs: Although WRNs of **both countries** were committed to their PPD their employers were not necessarily as committed to each individual's PPD plans. Women through experience found employers focused their PPD support in line with their own agendas that did not reflect individual PPD plans. This approach had a profound effect on many women. Service needs such as running the service taking priority above planning provisions for PPD was found to be a common experience. Short staffing was again given as a reason for why no PPD support was available. Some women waited a long time to gain support from their employers. This resulted in several women becoming disappointed when they did not get the support within the promised time scale, and as a result decided to take various courses of action and decisions, from accepting employers' part funding of courses to only studying subjects that the employer would support full funding for, and not necessarily the individual's subject of interest. Some decided not to undertake any PPD studies without full funding from the employer. Others sought to work for an employer who was more supportive of PPD, taking the risk to move jobs and even to moving to new geographical locations, moving homes and families or leaving them behind.

"Yes, I did apply for student leave, but there's always somebody else get a chance, or… They can't now because of shortage". Charlotte 9 SA

"Their team leader is saying 'we can't let them go because we haven't got the capacity staff wise. We're too busy". Helen 33 UK

Several **SA** RNs spoke about their employer having a Skills Development Funding (SDF) scheme linked to service needs with its own criteria as to what was institutionally applicable.

> *"If it's not accredited and they feel that it doesn't apply to the area that you're working in, they will decline your application… they're looking at what is applicable to the institution, but they're not looking at the individual itself, the long term plans".* Zika 41 SA

Line managers supporting nurses in different ways whilst also not supporting nurses: This category relates to line managers' behaviours towards WRNs in the workplace. One woman spoke of receiving support but also receiving negative behaviour from the same line manager. This "sting in the tail", indicated that these women were set boundaries by some spoken and unspoken rules that occurred between their line manager and themselves. So on the one hand they had received some degree of support, but on the other hand they had subjected themselves to being controlled by their line managers, who attempted to control their development and career progression. The control varied from they could not do anything about it, to allowing themselves to be controlled so that they could access the support given. Women also noticed that line managers who had been active in their own PPD, were more likely to be supportive than those who had not been actively involved in PPD.

"She's not very, very, supportive. Not interested … I don't talk a lot about my studies, you know. I keep a very low profile. It's much easier". Khahula 19 SA

"She offered me a lot of help and encouragement, but it was always with the proviso that – I didn't feel that I was a threat to her position. But she made it clear as long as I didn't earn more money than her". June 4 UK

"I think that a lot of managers really just sit in offices and order, they are not very interactive with their staff". Mandisa 23 SA

Line managers' influence and support towards PPD: As previously stated women noticed that line managers who had been active within their own PPD, were more likely to be supportive than those who had not been active in their own PPD.

"She is a role model … she's the one who always brings the courses and say the courses are available, who's willing to go for this and that". *Akua 6 SA*

"Some of my colleagues and they have also phoned me how is the studies going? How is that? We pray for you how is that, whatever, and my unit manager". Grace 39 SA

Some line managers acknowledged that the employing organisations had restrictions with regards to how much support they could offer in time and financially. However, they were creative in finding other ways to support women. For example, Dawn's manager found other courses that she could do. Karen's line manager was knowledgeable about money left over in budgets that could then be used to support her studies.

"I was able to do small, little courses that were running at the time". Dawn 32 UK

Role models: Women spoke of role models who had also influenced and supported their PPD. Examples of line managers as role models are provided in the following quotations. The most commonly mentioned were other RNs, friends and nurse educators/training managers.

"Lecturer working on the hospital site encouraged me to talk at a conference". Zika 41 SA

Education co-ordinator:

> *"It* was *really the one person. Because sometimes she herself actually had a struggle with the management above her for letting us do these sorts of things. She was very keen to let us do different training and that sort of thing but then she'd to go and almost sort of fight on our behalf, because again all down to funding and that sort of thing. She was really good".* **Dawn 32 UK**

> *"I've spoken to some of the other colleagues and they are really, you know, very supportive in the fact that they say - you must go, you must develop yourself further, you must go and do this and so on".* **Laura 19 SA**

Job criteria, promotion and recruitment strategies the new and old ways merging together: Both old and new ways were being implemented in the workplace. Women experienced a change in relation to job promotion and recruitment strategies. Women experienced the change that employers had made in job descriptions in that they had added to the essential criteria, stipulating some qualifications (for example these could be NMC or SANC registered qualifications), and/or qualifications set at a higher level, that were not previously required (for example those when commencing their jobs met the criteria by having a diploma, they then discovered that degrees were required and stated in these job descriptions). Other women were still experiencing some of the old ways (for example RNs who had worked for the employer for a long period of time were next in line for promotion, or RNs being favoured by senior staff not necessarily because of their skills or ability) prevented or made it difficult for them to apply and carryout new job roles, despite them having undertaken PPD activities and qualifications to satisfy the essential criteria in the job specifications.

Several young women (up to thirty years old) in **SA** were found to be interested in line management posts, but said they were told they could not apply unless they had 10 years or more of work experience. Women in the **UK** did not experience this.

> *"They feel threatened with young nurses that are coming on board, and they're studying. For them it feels as if we want to take their posts. Like now I did management, as if tomorrow I'll apply for her own post, of which I won't get that post because I don't have the experience. They always ask for 15 years' experience".* Akua 6 SA

It was evident that in **SA,** women perceived and experienced hidden rules surrounding job descriptions and promotion. So although PPD and gaining qualifications to meet job criteria gave women the choice to apply - these choices were sometimes removed by others, who used hidden rules and/or reverted to old ways of doing things: - "it's not what you know, it's who you know". None of the **UK** women spoke of similar experiences, though one UK woman spoke of reactions from other RNs when she was given a job in a hospital that she had not worked in before. She was treated as an outsider, by colleagues argued that they had demonstrated their loyalty to the hospital, by working there for a number of years, and believed they (rather than her) should have been offered the job.

> *"These particular people caused problems for me …When I was interviewing people for jobs …. They got their jobs on merit … what their attributes were … how they wanted to develop … I didn't necessarily look at how long they'd been qualified…* But it's almost like it should be given to them because they've worked there". Anna 27 UK

White **SA** women facing threat of no future employability: One SA white nurse had experienced SA's BEE (2013) working against her, when trying to apply for jobs. She experienced that the qualifications she held were equal to other applicants. However, line managers and work colleagues implied she would be unsuccessful in job applications, because of her white skin referring to SA BEE policy that promotes positive employment of black and coloured people.

> *"For each post that I have applied for… they did not take into consideration my qualifications … they would come around and they would tell me –remember if there's anybody with another colour skin that applies for the post, and they are suitable, they will get the post before you".* Khuhala 19 SA.

No other women in this study raised this issue, however only two white **SA** women were participants in this study[19].

In order to be able to remain employable and apply for jobs in the future, RNs needed to update their PPD to ensure they met the job specification for future jobs. This could be in the form of experience, informal and formal PPD. Women from the UK had experienced a change in job specification, some had experienced departmental changes that resulted in RN's having to reapply for jobs, and some had experienced downgrading.

"They've changed that as well since I qualified, that they really want degree nurses for Band 6 positions". Emily 34 UK

"Some places they're trying to shortlist using qualifications so some jobs are saying you need two years' experience; some jobs are saying you need a degree and if you don't have a degree then you can't apply". Karen 35 UK

"There was talk of restructure and possibly re-banding us – like it's happening all over the country really – and it was, you know, we might have to go up for interview against each other and there was a lot of uneasiness".

> Helen 33 UK*"It sounds like I'm blaming but it was the restructuring really. It was just that uneasiness that basically I didn't have the motivation at the time ... I feel like it's quashed it …. When they're saying that they're going to down-band you and you don't know where you're going to be working at and then you get formal letters through the post".* May 3 UK

Unsupportive attitudes and negative behaviours in work: Women from **both countries** experienced difficulties in getting changes to their work shifts, so that they could engage with PPD activities. An example of other women protesting that they too need to work certain shifts, for financial and/or childcare duties was often given. Several complained that they had a higher

[19] Race and ethnicity was not raised by UK women this may have been due to the lack of women from different backgrounds and the regional area in which the recruitment took place.

workload, because of other members of the team being absent on study leave. Others said that staff didn't show any interest in or support for their attempts to undertake PPD activities.

"Senior sisters do the off-duty, they do not care about the junior sisters … do whatever they want to do. But as soon as you as a junior wants to do that, it's like you are curbed until a certain point". Laura 16 SA

One **SA** RN struggled to get suitable shifts and study time, so resorted to having to take annual leave to study only to be told she could not do this by her line manager. This response demonstrated that the line manager did not want this woman to undertake PPD regardless of it being in paid or unpaid work time, she threatened to get the union involved.

"So I told her I don't owe you any answers because this is my leave, so I don't need to explain to you what I'm going to do in my leave time. So then she said - Oh okay". Esona 14 SA

Whilst some single women and women married with no children from **both countries** were viewed by other WRNs as having more time than women with children, they experienced negative comments, implying that it was less effort for these women to be successful in their studies, than for those with children.

"I've still got to clean my kitchen whether I have three children or no children. It's a bit of a grey area isn't it?" Esther 31 UK.

"They aren't married with children. I think that's the big thing. A lot of them live at home with mum and that's I think that's how they did it". Eleanor 30 UK

Several **SA** women experienced team members not understanding why they were carrying out further study/PPD activities. PPD was viewed as taking action that would create a distance amongst the group members because they would become "different" from the rest of the team, therefore not be the same as everyone else.

"What's wrong with you? Why don't you just relax and do your thing?" Grace 39 SA

Grade and status were viewed by WRNs from **both countries** as being influential in gaining more time for personal development activities: Women viewed other nurses of different grades having greater access to support for PPD, than themselves. **UK** women paid on higher grades perceived lower graded staff could be released more easily from the workplace to undertake PPD activities, because there were more staff employed on that grade who could cover for them. For staff on higher grades there was no one else of their grade available to cover for their absence on the ward.

This was also the case for several **SA** women. Those women who had qualified as nurses within the last 5-8 years, argued they were told by their employers that they would not receive any support for PPD (apart from in-service days and the SA exam day). They claimed that RNs on specialist grades had taken priority, because employers were focusing on giving support to RNs who were granted specialist grades when the OSD was introduced, and to stay on this grade these RNs had to complete the stated qualifications within the timescale set by the government.

"We're just left behind and that's why we're running away from Government because there's no way they're going to train you for anything for the next two or three years …. and how old will they be by then? Nobody cares…. Young people we want to study and we want to develop and grow and we don't want to wait years and years and years to actually get there". Nesiwe 24 SA

Access to PPD time within paid working hours: Women from **both countries** requested shifts or annual leave so that they could attend taught sessions or complete PPD activities. Flexible shift working hours assisted in this. It was noted that employers had control over access to nurses working shift duties, and a few experienced difficulties with the work rota, with requests for shifts or annual leave not being honoured.

"I'd do four hours in the morning; get up early and do until 12 o'clock before I had to leave for work… being able to double up shifts gives you an extra day". Amy 28 UK

"So I told her I don't owe you any answers because this is my leave, so I don't need to explain to you what I'm going to do in my leave time. So then she said - Oh okay". Esona 14 SA

> *"Being the ward manager at the time it was hard … it had to be in my own time so I had to have certain days off which then meant I was working more weekends, some of the staff actually said you're working weekends because you get more pay, then I had to end it … to keep the staff happy".* Natalie 36

Quiet time at work: Three women from each **of the countries** stated that they could find quiet time at work. For these women sometimes their line managers supported them in using quiet time to study. The majority of women said that they did not have the opportunity, and for some their work speciality/area was always busy. The lack of time to study at work slowed down their progression within their PPD activities. A minority of older women in their 40's reflected on the past, when the work environment was not as busy as currently.

"It's always full, and we are working very hard actually". Wazini 40 SA

"Able to study at work due to work area and rest time for the patients… and the … team support this". Akua 6 SA

Access to paid time: Women spoke of having no one to cover their absence from the workplace, giving reasons such as a lack of staffing and skill mix which prevented access to time for PPD activities during paid and unpaid working hours. Some could not be released from the workplace to attend PPD activities that required "face to face" or/and taught engagement.

"They can't now because of shortage". Charlotte 9 SA

Fragmented time: The majority of women could rarely access large chunks of un-interrupted study time (often required for academic courses) due to work and family commitments.

"The Christmas module is not good for me because I've family". Esther 31 UK

Not finishing work on time: This was most common for **UK women and SA** women who worked in rural areas (many **SA** women who had worked in city areas stated the opposite, that they always finished work on time). Those not finishing work on time stated how this affected their PPD. It reduced their time outside of work, and also had an impact on their other responsibilities in the home. It resulted in them having less time to study outside of paid working hours.

"Staff do not finish on time, they don't get paid extra hours but have it as time owing. It can be 15 minutes to an hour and a half". May 3 UK

Personal Time: For some women from **both countries**, there was very little time to study at home due to their circumstances at home, and this was compounded when their employers did not offer paid time to study. For some women it left them with no option but to study late into the night, in order to be able to complete the courses they were studying. This had an impact on relationships with their partners, families and friends.

Most of my studying I do at night, so everyone sleeps … I have a three year old … From about ten 'till three, or two". Mandisa 23 SA

"Sometimes I wouldn't even sleep, you know, there was just so much to do". Rebecca 21 SA

Withdrawing from social events was common, and this was a stress for women. They had little time to study, yet these social events acted as their support networks.

"You can't go to church because during the weekends…You don't have the time to socialise". Sisa 43 SA

Exhaustion of working and studying: This was found to be the most common category across **both countries** from all of the categories in this study. Women from different roles, status, family backgrounds and ages all raised the issue of exhaustion due to studying and working at the same time. Women explained they felt mentally and physically drained from doing their jobs as a RN and that PPD often involved academic studying which also exhausted them. The physical and mental work and the responsibilities at home, drained them of energy. This exhaustion also included the financial concerns of paying courses fees and the additional hidden costs of PPD.

For others they had no other option but to phone in sick.

> *"I know some people will, when they need to do assignments and do stuff, then they will just take off sick just to get the stuff done. If it comes to that, and I must do it, I must take a 'Benylin day' to complete your assignment, and there was a good reason why I couldn't do it, then I will do it, because my studies come first now, but otherwise you will, you must plan".* Grace 39 SA

Some women had experie[20]nced failure, because the time was wrong for them, and their families, and they reflected that they had not undertaken enough planning, nor achieved enough balance to be successful in their studies. Some had not anticipated the hidden costs of PPD (theme 3).

"I was doing it on my own, so it does have an impact because if you don't have study leave you must use your days, then when you come back to work you are so tired. So you can't function". Akua 6 SA

Akua also commented that many women do not complete their Masters' studies, for it can take on average 6 years because for many of RN's, employers are not granting paid time for them to carry out their studies.

[20] Benylin is the name of cough mixture for sickness, this is a term used in SA

Stress: Women from **both countries** spoke of experiencing stress. Examples included: Having to complete a set qualifying programme expected by their employer in order to meet the essential criteria in their job description, with a deadline date for completion. Receiving financial funding from their employer to undertake the PPD activity with the worry of failure which may result in having to pay back the grant. Taking on a new job role and undertaking PPD activities as stipulated by the employer (this was only raised by **UK** women): the worry of failure, and/or failure to complete the programme of studies.

"We are just two months in the course, so I'm still struggling. I feel though the train is running there, and I'm just constantly behind". ***Khuhala 19 SA***

Some **SA** women had to relocate to another part of SA to undertake full time study for 6 to 12 months of that year. Many did not have enough money to pay for the travel home, and the cheapest mode of travel was by bus which might take many days. Women spoke of the stress that this put on them and their families.

"I only go say once a month maybe … Every time I see my kids when I must go, then they are crying". Grace 39 SA

Not being able to afford a computer or internet access: A few nurses in the **UK and SA** spoke of not being able to afford these essential resources required for their academic studies. April 4 UK could not get internet access due to living in a rural area. Akua 6 SA and Charlotte 9 SA said they could not afford the internet and computers, so had to go into university to access them. Hence, they had to pay travel costs to get to the university. Wazini 40 SA said she had to use her mobile phone to access the internet, and then download articles onto the computer.

Phoning in sick: A few women reported that RNs need to phone into work as sick. For many this was a means to rest, recover and for some to relieve their worries of the pressures of PPD by providing space from working and home responsibilities.

"It was not my plan, but because of the circumstances that I'm currently in I have to do it like that". Bukeka 7 SA

Two **SA** women spoke of private employers' HR policies in relation to sick leave. Their experience was that if RNs took sick leave, and their employee HR record identified them as undertaking PPD studies, they were called to a meeting with their line managers, sooner than another employee who was not recorded as carrying out PPD studies. This situation was reported by Angela 12 SA whom, was working in the private sector.

Space to study: Women from **both countries** were not getting the space to study at work or during paid working hours. This in turn led them to having to find space in other areas outside of the work area. Outside paid working hours space to study was experienced in different ways. Some women struggled to find a physical space in their own homes. Others admitted that they themselves had put less onus on their PPD needs, acknowledging they themselves had prioritised their partner's and children's needs above their own needs.

Women found that when their children were in the house, they could not study very well. Other women said they would get distracted by undertaking housework and other household responsibilities.

"I'll think 'oh the washing machine's is finished. I'll go and peg the laundry out' or 'oh the floor could do with a bit of a clean …I'm really easily distracted". Danielle 46 UK

Space to study and access to the computer was often only after the rest of the family had used it. Some women prioritised their families' importance above their own. For many women there was only space to study when their responsibilities had been completed and other members of the household were either asleep or out of the home.

"I tend to do a lot when the kids have gone to bed". Danielle 46 UK

It was found that many women studied late at night, and they acknowledged that this was the most ineffective time for them to study because they were tired, having worked all day. But some had no choice because this was the only time they had to study and write essays.

"I have to start from nine, and then I get in bed about three o'clock in the morning, then I have to stand up six o'clock again and, you know, do the day job first and then that is the routine". Charlotte 9 SA

Professional Development activities encroaching on nurses' personal lives outside of paid working hours: Some women experienced professional development as becoming too personal, because it encroached on the individual's time, finances, social lives and home lives and which in turn had had a negative impact on their lives. They described such impacts: the breakdown of relationships (partners, husbands, friends and family members), less time spent with their children, and less quality time to relax and enjoy themselves. Sacrifice in using annual leave to study instead of having a break or perhaps going on holiday, spending less time with friends and family, and not being able to pursue interests and hobbies or attend church.

Male partners questioning what the rewards would be from doing PPD: Women from **both countries** experienced this to be a common question from their male partners. Some men asked this question in order to try to understand what women perceived the rewards and benefits to be.

"I always get an 'oh do you get a pay rise for this course then? …I reply… No love, but I might get a promotion if I want one with all of these courses, so that's a pay rise isn't it?" Emily 34 UK

Other men would only view benefits in the form of financial reward, disregarding any other reasons given by their women partners, and reacting by not offering support towards their PPD activities. Some were said to be deliberately obstructive questioning to why they were spending time outside

of paid work time studying. Lacking of understanding to why "their women partners" valued engaging in PPD:

"I have been told in the past enough is enough and he'll say to me. Tell me what difference doing all of these courses is going to make you at work. Are you going to get paid more? … I'll say in this particular job I'm doing now, no". Jane 29 UK

Also involved is lack of funding, time, space and support within the work environment and outside the work environment, the physical and emotional exhaustion of studying and working at the same time, and having to phone in sick because of feeling unwell (many such women had not been given any paid time for study leave).

To summarise, the categories in the 2nd sub-theme are mainly about women's jobs as RNs and their employing organisations and the support given and denied by employers for PPD activities. They also describe WRNs' struggles to gain support inside and outside of the work environment, the effects on their health and the challenges of obtaining qualifications that are essential requirements for some jobs. The experiences and perceptions that **SA** RNs hold with regards to whether private or public employers offer the best opportunities for PPD are also considered, and finally a cultural issue of **SA** white women experiencing difficulties in employability due to the "colour of their skin" [21] is raised. These findings reveal the extent of the difficulties that women from **both SA and the UK** have had in undertaking PPD journeys, with minimal support for the majority.

4.2.3 Rewards and benefits- 3rd sub-theme

Benefits and rewards that WRNs said they had gained from their PPD activities constituted several categories: personal achievement, confidence, employability, and an opportunity to increase their financial status. For

[21] This is in relation to the SA BEE policy that discriminates against white women.

several women from **both countries** this achievement was celebrated with their partners, who were proud of their success. Another category was identified for those who were mothers of children living in the home, whereby their children viewed their mothers as role models, teaching them life skills that working hard to learn and study for qualifications would lead to betterment. Some WRNs spoke about how they had become role models to other RNs, who had started to approach them for advice. They were also approached by senior staff who offered opportunities.

Some women worked towards the benefits and rewards they expected to have such as completion of a course and updating knowledge that could lead to promotion.

"Salary will be good, but for myself I learnt stuff and nobody can take that away from you". Grace 39 SA

"I feel that in the area that I'm at, in also and in the position that I'm at, I'm actually allowed to apply what I've learned for the benefit of the patients, and also for the benefit of the staff". Zika 41 SA

But they also gained benefits along the way, which they had not been aware of until after completing their PPD activities.

Personal achievement: The most common answer with regards to personal achievement from the majority of women of **both countries** was the personal satisfaction of having achieved the ownership of a qualification/course.

"At the end of the day they can't take the qualification away from me". Anna 27 UK

"I would say self-satisfaction actually outweighed the more money side of it really". Dawn 32 UK

"The end result of achieving something so that's quite rewarding. I think there's only actually you can feel that". Esther 31 UK

Confidence: Women from **both countries** found they had become more confident in both their professional and personal lives. Examples they gave included: to challenge processes within the hierarchical work environment and to challenge the standards/treatments being given to their patients/clients/ others, inside and outside of work. They were able to understand and interpret research findings better than before. Some women also spoke of their increase in confidence in their daily lives outside work, and that others had commented on this.

"Certainly a lot more confidence just with coping with life and things". Anna 27 UK

"I think knowledge is quite … not power but it's quite, it helps with your confidence". Dawn 32 UK

"Become more assertive in asking questions". Sisa 43 SA

"I always a bit scared, you know I was always okay, that's what you said? Okay, that's it. It's fine. But now I've learnt to question, I've learnt to ask, explain to me. Tell me why, you know, so it's made a big difference". Zika 41 SA

Employability: This had different meanings according to the individual's circumstances, but for all women future employability linked with job security and pay. Several **UK** women were aware of the changes made to some job descriptions which had placed named qualifications as essential criteria for the job. For some women from **both countries** it was through potential restructuring that they found they may have to re-apply for their current job (which when they started the job did not state named qualifications that were subsequently required). For others in **SA** to be paid on a specialist grade required them to complete a named qualification within a set time-period to keep their pay grade.

"I had to, it's part of the job I've got to do it. If I don't do it, if I don't pass it, then I probably won't have a job anyway". Natalie 35 UK

> *"It was a forced thing also, you could say, because we were told that we've got a four year period where, because I was in a*

> *specialist post as well, but I didn't do the course yet. So we had that four year period where we could do it, but if we didn't then we would drop our notches again".* Zika 41 SA

For other women from **both countries** completing their PPD activities gave them the choice to be able to apply for a job in the future, "should they wish to do so" or to support a future job application once they had also acquired the number of years of experience (**SA** women only) also required for the job.

"By sort of doing the extra qualifications and things it meant that if jobs came up I could then apply for them because I'd done the courses and things like that". Dawn 32 UK

"I had a choice. Or I could apply for another post". Khahula 19 SA

Financial: For many women from **both countries** increase in salary, by being able to apply for and successfully gain a higher graded job would offer a better standard of living for themselves and/or for their current or future families.

"As a family? Yeah and I suppose as well as the financial side of the things and having a permanent job, that enabled us to, you know, to live, if you like, to have holidays and things". June 4 UK

"I was like over the moon because I know my life will change now, you now". Esona 14 SA

"It's given me security now because, at the end of the day, I'm a single parent … I've got more doors that could open now". Anna 27 UK

Some **SA** RNs benefitted by successfully demonstrating to their employers the PPD activities they had been involved in. They were rewarded with a monetary bonus, which could be spent on anything they liked.

"I spent my bonuses on that and I was able then to achieve what I set out to achieve". Rebecca 21 SA

Role model to children: Several women from **both countries** described their children observing them study and for some of the women their children studied alongside them. Women felt this was teaching their children life skills and habits that would be of benefit in the future. Their children could also view their mothers as role models and someone they could be proud of.

> *"Now today it actually motivated my children to go study. Because my eldest son said - you were actually an example for me, that you just stood up and told yourself, no, I want to need, I want more out of life than this. And now he's at University".* Charlotte 9 SA

Celebrate success with their partners: Women from **both countries** wanted to celebrate their achievements with their partners (those who had supported their PPD activities), and they could both enjoy the benefits that might come with their achievement. Women such as Dawn 32 UK spoke about the pride that their partners had of the achievements they had gained.

Acting as a role model to other RNs and being offered opportunities: a few women spoke about their reputation being enhanced, acting as a role model to others, and being offered opportunities to do things that they had not experienced in the past.

"It's opened a lot of doors to a lot of things …. Promotion … others citing her as an example to other nurses, being a role model". Esona 14 SA

To summarise: this 3rd sub-theme on the benefits and rewards of PPD revealed benefits and rewards that were mainly personal rather than professional. Personal achievement and confidence were more commonly cited than the financial reward gained from being able to successfully apply for a higher status job with higher pay. For some women the benefit was that they could be 'one step ahead of the game' and continue to remain employable. For others it was about having the choice, if they wished, to apply for other jobs. The benefits and rewards women did not anticipate

were: gaining confidence inside and outside of work, being a role model to their children, and celebrating their success with their partners.

"Oh yeah he is. I think he's quite pleased really that I'm doing something, progressing and that". Emily 34 UK

This Core Theme 1 has highlighted women's perceptions, experiences, benefits and rewards of PPD activities. It showed that **UK and SA** women held a general perception about what personal and professional development meant to them as RNs. This was that RNs need to grow, and to continue to develop and learn. PPD is about having self-awareness: keeping up-to date in the speciality they work in and with their work organisations' latest policies and procedures.

The majority of **SA** women perceived Personal Development and Professional Development to be linked, joined together or merging at certain points. Some of these perceptions challenged the theoretical ideas around PPD. What is clear from these findings is that women had different opinions about whether PPD was joined together or separate. The reasons behind this were down to the funding and whether support was offered (or not) by employers. Personal development was, for many, perceived as their own individual professional and career development and the majority did not perceive or experience employers supporting their professional/career development.

UK and SA women's experiences in relation to support for PPD activities inside and outside of work were not altogether positive. Only a minority of WRNs experienced their line managers offering positive support. Only two **SA** RNs spoke about their line managers organising teaching sessions on the ward, to ensure RNs could develop their specialist knowledge and skills. The majority of women from **both countries** said the work area was too busy. Some women also had difficulties at home, where sometime there was

a difference of opinion from male partners as to what should be the benefits and rewards for carrying out PPD activities outside of paid working hours. Some women worked towards the benefits and rewards that they perceived they would gain to support them in their current job roles. Women were also found to gain benefits and rewards along the way, some of which they had not anticipated, until after completing their PPD activities. The reward of gaining academic qualifications and undertaking other courses as part of women's PPD, can also lead to applying, and being successful in applying, for higher paid jobs. Women valued the personal achievement, increased confidence and having the option to apply for a job, far more than the financial rewards.

Chapter 5: **Findings of the 2, 3rd and 4th main themes**

This chapter is focused on the main themes 2nd, 3rd, 4th that emerged from the core 1st Theme and contributed to the construction of the emerging PPD Model.

5.1 Women's perceptions and experiences of engagement, aspirations and circumstances that can influence and/or limit PPD - 2nd Main Theme

This 2nd Main Theme explored the levels of engagement that women undertook in their PPD activities, aspirations and circumstances that can influence and limit PPD activities, in more depth. This theme captures the realities of PPD for many women RNs from **both countries**.

5.1.1 Women's perceptions of employer-led PPD - 1st sub-theme:

Women from **both countries** perceived what they viewed as employer-led PPD. Employer-led PPD (below Figure 4) was perceived to have its focus on the employing organisation and what level of engagement it wanted its employees to have, and not on PPD activities that would necessarily support women's careers and their own personal and professional development.

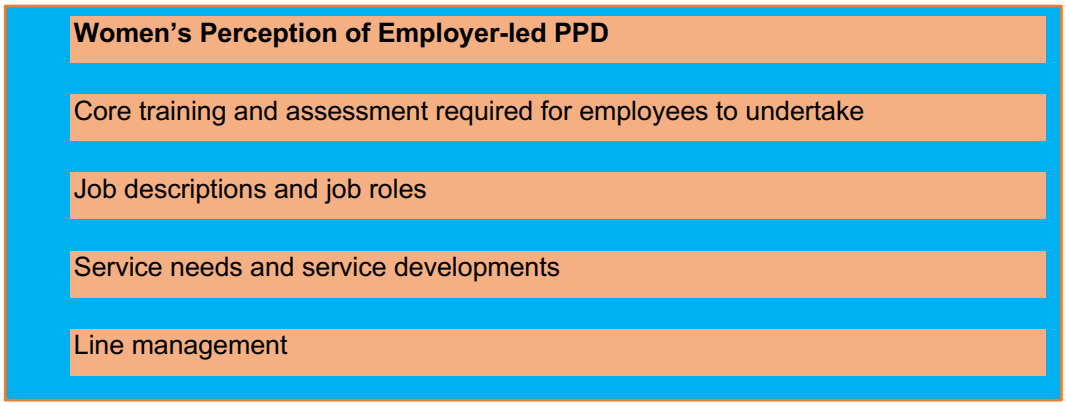

Figure 4 Women's perception of employer-led PPD

Core Training and Assessment requirements were mentioned by women as requirements for employees to undertake and stated within their work contracts. Once women had qualified to be registered nurses, they perceived that PPD for the employer was thought to consist of undertaking in-service/mandatory training (core training and assessment), and any additional training stipulated by the employer.

These PPD activities support women's re-registration on the nursing register.

"You've got your mandatory stuff that obviously you need to know your basics as a nurse". Eleanor 30 UK

Women recognised that employers' requirements were for them to carry out their duties as stated in their job role description, in a competent manner. Differences in these were found in the **UK**, where several women said they were expected to undertake PPD activities to obtain experience and qualifications stated in the essential/desirable sections of their job descriptions. In **SA**, nurses had been given specialist nurse grades through the OSD/ SPMS initiative, and as a result they had to achieve named qualifications (at a stipulated academic level) by a set date to meet the set criteria otherwise they would be down-graded.

Women viewed the employers as being focused on the services' rather than an individual's needs. Many women experienced working for employers who gave them none or very little support for their PPD activities offering limited opportunities.

> *"Will only support you if you are not only developing your needs but developing the needs of the Service. So if you're saying to me you want to get extra modules because you want to top up from a Diploma to a Degree, we'll probably say 'no' … I don't think there's as much support for that as they make it out to be."* Karen 35 UK

In contrast, one **UK** woman said that she had felt her request would support service needs.

"They supported me in the fact that they'd agreed through appraisal that I could do the nurse practitioner course". Anna 27 UK

Line managers were seen as an extension of the employer and/or the representative of the employer. For many women, they had the view that line managers played the role as the gatekeeper of PPD activities, placing priority on getting their staff to complete mandatory and service needs trainings in order to meet the goals and dates set by the employing organisation. Appraisal reviews were seen by many to be mainly focused on the organisation and the job role, and not necessarily on the individual's personal development plans. Some women said that their line managers did not carry out appraisals. Thus appraisals were perceived to be only carried out when the line manager wished it, and not when the individual wished or when they wanted to discuss their development needs.

"I am telling you that these things should have been done, but it's not always done in the workplace, it's not". Pam 13 SA

To summarise in this 1st sub-theme, WRNs from **both countries** were found to perceive what they viewed as employer-led PPD (Figure 4), consisting of PPD activities that were essential to the service provision. Women's perception of employer-led PPD is that employers recruit and employ RNs and offer them core training (mandatory or in-service), and opportunities for development. The line manager plays an important role in undertaking appraisals that will evaluate RNs' performance within their job role and may establish further training and development opportunities. Some women received support for further training and development that would also enhance their careers. However, for the majority this did not happen. They perceived the employer as only focused on service provision and not the individual's PPD needs that would support WRNs careers. Several WRNs did not receive core training nor appraisal meetings with their line manager.

This Women's perception of employer-led PPD (1st sub-theme, 5.1.1, Figure 4) led to recognition of a difference of continuum of perceptions as to what

women perceived as PPD, alongside this was Nurse led PPD (2nd sub-theme, 5.1.2, below Figure 5) this is explained in the following section. This 2nd sub-theme on women's engagement, perception and definitions of PPD activity found a division between women's perceptions of employer-led PPD and nurse-led PPD. Both of these perceptions formed a basis for the emerging PPD Model (Chapter 6, Figure 6). The two perceptions of PPD have equal weighting and acted as a foundation for building the PPD Model (Chapter 6, Figure 6).

5.1.2 Women's Engagement, perception and definitions of Nurse led PPD – 2nd sub-theme

Women from **both countries** had similar perceptions as to what they defined to be nurse-led PPD (Figure 5 below). To define this in broad terms, nurse-led PPD is when the individual shapes their own career and impresses upon their own personal and professional development (though a few WRNs had recognised that their employers may have had a part in shaping their careers, by offering support and funding for training and education).

Women's Perception of Nurse Led PPD; the differing levels of engagement in PPD

A) A job role as an RN: PPD core training and assessment.

B) A job role as an RN: PPD to keep the nursing role interesting.

C) A job role as an RN: PPD to adapt to the changes in the job role.

D) A job role as an RN: PPD to remain employable and to be up to date with knowledge, skills and qualifications and to accommodate the changing service needs.

E) A new job role: PPD knowledge, skills and qualifications that need to be achieved by a set date.

F) A job role as an RN: PPD knowledge, skills and qualifications that facilitate women's aspirations.

Women were found to move from different levels of PPD activity (see A-F above) depending on their **perception** and their individual **circumstances. The hidden costs of PPD** were also found to affect the level of engagement, and for some they felt they had to move from one level to another.

Figure 5 Women's perception of Nurse Led PPD

The levels of engagement fell into a continuum from what was perceived to be the basic, lowest level (a) to the higher, more advanced levels of engagement (f) as presented above in Figure 5.

A job role as an RN: PPD core training and assessment (Level A): Women spoke of the times in which they had engaged at the minimum level, and of nursing colleagues who had only engaged at the level.

A job role: as an RN: PPD to keep the nursing role interesting (Level B): Several women spoke of the informal PPD activities they undertook to keep themselves updated and to continue to develop their knowledge.

PPD to adapt to changes in the job role (Level C): Several women experienced their job roles and/or their nursing specialities changing. This resulted in them wanting and/or needing to develop their knowledge and skills on caring for patients in these specialities. This involved a low level of engagement in PPD activities inside and outside of paid working hours.

PPD to remain employable and be up to date with knowledge, skills and qualifications to accommodate the changing service needs (Level D): Several women showed awareness of the potential and future changes in health care organisations. They examined what these changes could consist of and prepared themselves to be ready for these changes by engaging in PPD activities. This involved a low to medium level of engagement in PPD activities inside and outside of paid working hours.

PPD knowledge, skills and assessment that needed to be achieved by a set date (Level E): Several WRNs experienced changes in their job role and pay scale, and as a result of this, they were given a set time to achieve knowledge, skills and assessment that would allow them to continue in job roles within their work areas. Others sought new jobs with new pay scales, with the awareness that they would have a set time to achieve knowledge, skills and assessment. This involved a medium to high level of engagement in PPD activities inside and outside of paid working hours.

PPD knowledge, skills and qualifications that facilitate women's aspirations (Level F): Several women knew what they wanted to achieve in their future careers. They explored the options and sought development opportunities in order to achieve their aspirations. This involved a medium to high level of engagement in PPD activities inside and outside of paid working hours.

Women were found to class the level of engagement in terms of: the level of academic study, the time put into this study inside and outside of working hours, the period of time over months and years needed to undertake the activity and the level of difficulty. The differences between the lowest and

highest levels of engagement were most commonly found to be based on the time needed for the activity (inside and outside of paid work). Hence the lowest level of engagement of PPD activity comprised activities that were undertaken in the workplace, during paid working hours and did not result in the RN having to self-fund or use unpaid time to complete the level of activity. The level of academic study, time and the amount of effort put into PPD activities and study by the individual, was found to involve a much higher level.

Women viewed PPD activities as only engaging in core training and assessment and thought that these PPD activities should only be undertaken at work, within paid working hours. In the **UK**, this differed as several women were found to be undertaking some of these core PPD activities outside of paid working hours with the agreement to take time owing back at a later stage, whereas this was not experienced in **SA**. Several women spoke of not wishing to develop themselves further, that this was their main reasons for only engaging on the lowest level.

> *"They think that once they are qualified they've got that qualification under their belt they don't need to do anything else … some people are happy just to come to work, do what they're going to do and collect their wages at the end of the month and plod along. They do provide good care … they don't want the commitment of doing stuff out of work".* Jane 29

"Lots of people they don't want to study any further, they don't have any ambition to do something else after they've done their basic degree or whatever". Khuhala 19 SA

Reasons based around the requirements of academic study: These reasons varied for example some women experienced nurse training to be very hard. On having achieved their nursing qualification, they had no desire to do any further studying. It should be noted that several women in this research had worked in the healthcare sector (between 1-20 years so this is regardless of

when they trained, gaining academic qualifications during that time to be able to enter nurse training). For some of those who had experienced that struggle, they didn't wish to put themselves through further study and the perceived worry of the risk of failure. Several did not have the confidence and/or perceived they did not have the academic ability to pass PPD activities that involved written assessment at the same or at a higher academic level than experienced within their nurse training, "not academic" was a common term used by **both SA and UK** WRNs.

"They've been trained in things that I wasn't. So it's maybe more of a factor that I haven't have that academic background. It makes me have to work harder, put in more time which is valuable already". May 3 UK

Differing levels of engagement within women's lives: Many women conceptualised PPD as having differing levels, from minimum to maximum, and that they moved and changed from one level to another during their working lives. They gave many different reasons as to why this had happened: Women from **both countries** gave their own examples of their different levels of engagement during their working lives. For several women they expressed that unlike other women, they did not stay on the minimal level of PPD activities. Women's reflection on what was happening in their lives at the time included their personal circumstances and reasoning, and this was an important factor for them.

The reasons why women changed their level of engagement in PPD activity were complex. What was apparent was that many women put it down to simply being due to their current circumstances, and the change of circumstances that they had experienced at their different stages of life (see Appendix A for the circumstances that show cultural differences between **SA and the UK**). Circumstances could be work, home and/or personal. For a few women it was just one circumstance, however for many it was a combination of several circumstances that affected changes made in their level of engagement in PPD activities.

Employers' demands, and changing circumstances: What should be noted is that several women from **both countries** experienced the change of engagement in PPD activities due to their employer's demands on them, to be RNs working in the service with named qualifications as raised in the 1st sub-theme Women's perception of employer led PPD (Figure 4) (regardless of the individual's own wishes).

One nurse gave an example of the service needs enforcing her to study for a specific qualification to meet service requirements. Another nurse had a similar experience, whereby she was required to study for a higher level of qualification.

"My employer wanted me to do it and I didn't want to do it. I didn't think it was necessary for me to come to school at 55 years old". Zoleka 37 SA

"A sickner [SIC], a shock, I would have liked to have had a break in between the degree and masters". Natalie 38 UK

Several women continued to be motivated to carry out PPD activities after they had achieved the goals set by their employer. This experience of engaging in PPD activities changed their approach and perception of PPD. For some they had selected future PPD activities, to achieve their own personal goals. This recognises that despite the overwhelming negativity that women experienced with regards to their employers' approach towards PPD, the employer-led PPD approach had resulted in having a positive influence on several women's PPD. Several continued to create and shape their own individual development and career plans. Others completed the goals set by their employer and chose not to engage in any further PPD.

Judgements made by line managers and/or employers as to whether the level of PPD engagement is permitted in relation to their personal circumstances: A few women raised the subject of their experiences in relation to the judgements made by employers as to whether or not they would give them opportunities to undertake PPD activities. This judgement

they argued was based on the woman's stage of life and their personal current circumstances. No regard was given to women's own individual perceptions and judgements of their personal circumstances as to whether or not it they felt that it was the right time for themselves to commence the desired PPD activity. These women spoke of not being able to engage more in PPD activities due to their employers' judgement, that resulted in employers making decisions, that included withholding permission for them to commence PDD activities. However, it was only 1 UK women who provided a clear example of this. Helen spoke about applying for a course that she wanted to do:

> *"I didn't get on the first time and I was absolutely devastated because that's where I wanted to be and what I wanted to do and the feedback was … You got married this year, the time was not right. I was absolutely devastated. I was thinking, NO. Yeah I'd got married that year, but actually I'm hungry for this, and I really, really want this".* Helen 33 UK

Women as nurses not changing their level of engagement at all, some choosing to engage only at the lowest PPD level: Several women from both countries explained that in their experience, some women only ever engaged in PPD at this basic level. They viewed these women as having no inclination to engage themselves in any further PPD activities. Identifying this decision making as to what level of engagement they wanted to engage in, often happened to women during their nurse training and/or on gaining their RN qualification.

"From being a student nurse I knew I wanted to be a district nursing team lead so that was it and there was no stopping me that was my drive and ambition". Helen 33 UK

Several women expressed that they too, had experienced and acted out this "perception of PPD" at one stage or another within their lives. Over time this perception and aspirations of PPD changed for them, but for many women, this perception stayed the same.

"Some people are just doing nursing so that they can get to the job. After that they don't worry about the other things … they forget about the study business". Bukeka 7 SA

"You could sit in the background it you didn't want to …Well now what I actually see are people with children, and busy lives and full time jobs recognising the importance of personal and professional development". Esther 31 UK

The lack of PPD and/or restriction of engagement in PPD activities by women: The research findings revealed that there were a number of reasons given as to why women were engaging only at the basic and minimal level of PPD activities. Some of these reasons overlapped with their personal circumstances (as discussed in more depth in the 4th sub-theme). Some were based around the refusal to carry out PPD activities outside of working hours, because they would be unpaid working hours.

"Some people don't see that it does impact on the personal … Some people say I'm not going to do it because it will impact on my personal life". Jane 29 UK

To summarise: Several women only undertook the lowest level engagement. Others spoke of their circumstances and priorities outside of work as being more important than committing to spend time on PPD activities that would have to be carried out within paid working hours. Several women wanted to keep learning about their nursing speciality, claiming that it kept the job interesting. This involved a low to medium level of engagement, inside and outside of paid working hours. When time was available and they were free of any other commitments or other priorities, they could do some study outside of paid working hours.

Women's Perception of PPD was found to be a continuum. The level of engagement with PPD differed from the basic level of engagement that employers expected of all RN's (this would also support RN's re-registration). The perception of PPD changed according to the individual woman's

perception PPD, the level of engagement of PPD is dependent on the job role she in and her own definition of PPD. on and/or the position within their job.

5.1.3 Nurses' aspirations that may be fulfilled through PPD activities – 3rd sub-theme

Several women from **both countries** were found to have aspirations, some of which could be fulfilled through their PPD activities. Aspirations were assumed to be driven by the individual's career ambition and goals that they wished to reach/achieve. The data analysis identified three key categories of aspirations: financial aspirations, professional aspirations and personal aspirations. It was found many women had aspirations in more than one of these categories. For several it was clear that the personal and professional were closely linked.

Several women made it clear that they aimed to engage within PPD activities, so that they could apply for jobs that would pay them a salary that they desired. Other women were aware that by engaging in PPD activities in which they would gain qualifications, they might be able to earn a higher salary, if a job came up. Several said that "the money would certainly help" with their personal finances, and assist in raising the standard of living for themselves and their families. Hence any assumptions as to why or what aspirations women had, could only be answered by the individual themselves.

"Better paid job, masters' qualification, skills, knowledge". Mary 11 SA

Financial: several women it was clear that they aimed to engage within PPD activities so that they could apply for jobs that would pay them a salary that they desired. Other women were aware that by engaging in PPD activities in which they would gain qualifications, it could lead to a higher paid job. Several women said that "the money would certainly help" with their personal finances and assist in a rise in living standard for them and their families.

Several women made it clear that earning more money was not the most important thing to them.

"Firstly the salary would increase obviously … Future career path … a stable job". Laura 16 SA

To earn a higher wage and work at a higher level was important to them, however for other women, financial gain was not necessarily their main goal/aspiration. Three SA women argued that financial gain should not be treated as an aim, for it detracted from the values placed on nursing.

"I know if I empower myself with learn I can earn more money and earn more knowledge to treat". Grace 39 SA

"I like nursing, it's not about money, it is my call". Anita 45 SA

Professional: Several women had aspired to gain a job role working in a preferred speciality or position, during or shortly after qualifying as a RN.

For others, as they progressed in their nursing careers, there were dreams of roles that they would like to do, and they undertook PPD activities that would help them to build up their knowledge and skills to undertake that dream job, should they wish to do so in the future.

Several of the women interviewed were concerned about the nursing care of people with specific conditions or diseases. For **SA** women they wanted to gain the masters qualifications that would permit them to set up their own private clinics[22], be self-employed in order to care for those in their communities, be independent and no longer to be employed by the government (often pay was better than working for the SA NHS).

"I noticed that HIV children die from hunger and defaulting treatment … I want to do a project HIV children to stay with me…that is my dream". Thulisa 42 SA

[22] There is no comparison to UK WRNs

One woman spoke about AIDS and HIV and the importance of family planning. *"One of my dreams was to always … have my own reproductive clinic, to run a place by myself, with maybe a team".* Pam 13 SA

> *"Be able to open my own midwifery, obstetric unit, and all those things…people are very poor in here, some of them, they can't afford the private sectors … coming from the rural area where maybe there's only one obstetric unit. People are dying".* Bukeka 7 SA

Personal: For several women there was a personal aspiration to gain a qualification at an academic level: certificate/diploma/degree/masters/PhD. For others it was to study and achieve a pass in a module or course within a subject specific area, and to have had the experience of studying at a university.

"I wanted to be a better individual, I want to give them more, and so I did it … Just want to see myself also being content, and fulfilled at the end of the day". Charlotte 9 SA

"I think I sort of knew within myself, I needed to study. I needed to study further to be able to achieve what I wanted to achieve and this was my ultimate goal". Rebecca 21 SA

"I want to get my master's, because I am also looking at doing a PhD". Bukeka 7 SA

Aspirations were found to influence women's engagement in PPD and ascertain to what level they wished to participate. For some women it was only at later stages in their lives they developed an aspiration, challenging beliefs that aspirations are only for those at beginning of their nursing careers and have high ambitions.

5.1.4 Circumstances– 4th sub-theme

It became apparent that there was a whole range of circumstances that WRNs from **both countries** found themselves in which came under 3 main categories: personal, at work, and in the home, all of which had an effect on their success and engagement in PPD activities. However, their reasons for

not engaging or struggling with engagement often stemmed from their individual circumstances. These circumstances could also be due to an event, or state of affairs which could limit the women's engagement in PPD.

"I don't want to do any more studying. The husband and the kids won't cope with it". ***Natalie 36 UK***

Change of circumstance in relation to their jobs included change in job role such as promotion, a temporary position, redundancy, re-location, suspension and relocation resulting in a new job. Change of job location varied from it being in the same area, a different area, a different building, or a move to a different geographical site. Changes also included the number of shifts/days/ hours worked per week, the days in the week worked and the type of shifts worked (day, night, early, late and twilight shifts). Changes in job circumstances resulted in RNs having to reconsider if and to what level of PPD engagement they needed to undertake in order to update and maintain their knowledge and skills for providing a good a standard of nursing care.

Changes made in service provision such as: a service previously provided could be developed, removed or replaced by other services. Changes being made in the service resulted in a direct impact on nursing knowledge and skills required to deliver the service. For example, Emily 34 UK undertook clinical courses on venepuncture and cannulation in recognition that extended nursing skills and knowledge could assist with meeting the service needs, provision and delivery of patient care. Another example was April 1 UK who said:

"I wanted to expand my nursing role…. It just gives more interest really".
April 1 UK

Changes in personal circumstances of the women involved in this study were: Change of marital status including new relationships, new partners, marriage, divorce, separation and becoming widowed. Change in geographical location having recently moved so that friends and family were living close by, not far away from childcare providers, close by to children's

school so able to work around the school operating hours, lower housing costs, partner/husband had a good job in the area, closer to better health care employers/organisations. Caring roles in relation to children: unsuccessful pregnancies, pregnancy, young children below school age, school age children, children at university, children left at home. Caring roles in relation to elderly parents and grandchildren. Women's health issues raised by a minority of research participants: menstrual cycle, pregnancy, In Vitro Fertilisation (IVF) treatments, physical injury as a result of nursing such as back problems. There was also stress within the job, stress in the home, and stress in academic study. A minority of the **SA** women stated that they had suffered mental and/or physical abuse in the home which had impacted on their level of engagement in PPD activities.

For some women the change of job was an action taken after their children were older and become less dependent. By making these changes, some women found they could benefit, as they no longer had to take into account childcare fees. Childcare costs were one of the main reasons for women undertaking night shift work and working part time hours. Other difficulties with engagement in PPD activities are explored in more depth in the remaining research themes, supported with participant quotations. For many women, engagement in PPD activities often stemmed from women's individual circumstances and personal reasons. Women who had aspirations to develop themselves further were found to be motivated to overcome the barriers or to wait until the "right time" came to undertake their PPD activities. This is discussed in more detail in the 4th Main Theme women's PPD journeys.

Below are some examples of the circumstances that **SA** women in this study found themselves in which prevented or worked against PPD that needed to be undertaken outside of paid working hours. In **SA** the standard shift pattern for the majority of RNs is 7am to 7pm. Very few RNs are given the

opportunity to work part-time hours. This has an impact on childcare, their personal safety, quality of life and their home and family lives.

> *"Lots of nurses in SA support families, they're single parents, they get on public transport, travel long distances before getting to work in the morning, or in the evening. They could travel for two hours, then they work a twelve hour shift, and the could travel two hours back home again, and they could do that for three days in a row, and they have quite hard lives".* Julie 44 SA

Women in the **UK** were also found to be working 12 hour shifts. However there are part-time jobs and a range of shift hours available for RNs.

"They wouldn't give me study leave …I would have to work my 3 x 12hours, and then do it in my own time". ***Jane 29 UK***

This 4th sub-theme demonstrates the range of circumstances that women from **both countries** encounter in their personal and professional lives. Any of these can influence or limit their engagement in PPD activities.

Summarising this 2nd Main Theme on Engagement, aspirations, and circumstances demonstrates that women's perceptions and experiences of PPD from **both countries** influences their levels of engagement. There were two distinct perceptions about engagement. The 1st sub-theme outlines women's perceptions of what they perceived to be Employer-led PPD. The 2nd sub-theme was women's perceptions of what they perceived to be Nurse led PPD. Women's perceptions of employer-led PPD, was that employers delivered, managed and controlled women's PPD and that WRNs were expected to engage in PPD activities offered by the employer. This revolved around four key categories: core training and assessment, performance within the job role and job description, service needs and service development, and line management. In contrast the 2nd sub-theme: Women's perception of Nurse- led PPD, recognise that women had differing perceptions as to what PPD was, relating it to their job role, and this in turn

affected how they perceived the level of engagement with PPD activities that was required.

The 3rd sub-theme described women's aspirations which they perceived could be fulfilled through undertaking PPD activities. These 3 key categories were found to be: financial, personal and professional, and women were found to have aspirations that related to more than one of these.

The 4th sub-theme was related to circumstances. Circumstances in women's lives (personal, inside and outside of work) were found to influence or limit engagement or contribute to success in PPD activities.

Overall, it was found what influenced and/or limited PPD activities and played a crucial role in understanding the dynamics of PPD for women working as nurses. It became apparent that the individual circumstances that women found themselves in personally, at work and in the home had an effect on women's success and level of engagement in PPD activities.

5.2 The Hidden costs of PPD and the strategies and techniques women used to overcome the difficulties – Main Theme 3

Main theme 3 leads on from the perceptions, experiences and benefits of PPD activities to emphasise and deepen categories to avoid belittling women's experiences, and to empathise with the hidden costs of PPD which were found to be stressful, emotionally and physically demanding, financially draining and very time consuming. At the same time the study revealed what was both personal and professional to the women.

These costs needed to be acknowledged for two reasons. Firstly to show that undertaking PPD activities can be very difficult for women, and the costs can be much higher than anticipated. For several women the "hidden" costs had been too high and resulted in a negative experience and unsuccessful PPD activities/studies. Others did not engage in any level higher than the basic level of PPD engagement. This was because the WRNs did not wish to encounter these costs, having heard from others what they might be, or their partners or families would not let them engage in PPD activities because of the potential disruption to family life that would lead to a change in the way they managed their responsibilities within the home and family.

These findings empathise in more depth the impact these hidden costs had on women from **both countries**, in relation to their PPD activities and for those that held responsibilities outside the workplace. The findings also show how these costs lead the women to use effective strategies and techniques to challenge and overcome them and support them to engage effectively in PPD activities.

5.2.1 Hidden Costs of PPD – 1st sub-theme

This sub-theme acts as a reminder and emphasises in more depth the hidden costs, which made it difficult for women to be successful in engaging in PPD activities. The sub-theme also highlights the amount of stress women

experienced when trying to engage in PPD and navigate these hidden costs. Time was also a big issue for women, and one of the most common stressors they experienced. The following categories demonstrate the wide range of hidden costs raised in this study.

Unsupportive attitudes and behaviours outside of work from male partners/ husbands: **SA** women, more so than **UK** women, experienced negative behaviour from their male partners such as complaining, obstructing study, violence, abuse, and jealousy. A minority of women said that their engagement in PPD activities had been a contributing factor in putting strain on personal relationships.

Three women from both countries talked about a breakdown in relationships because of them wanting to study. They had not anticipated this would be a hidden cost of PPD. They expressed disappointment, in their partners' failure to understand. "Enough is enough" was the way in which one UK husband put a stop to the time that one woman spent on undertaking PPD activities in the home (whilst he was in the home). For many women there was no guarantee that on achievement of their PPD activities, there would be an increase in wages or a better job. This had made it harder for women to convince their partners to support them.

> *"You sort of think, is it jealousy that I'm sort of developing myself and my role rather than being content on the situation that I'm in? … I suppose in other people's words, being pushed out – putting studying over your family which I don't think I've intentionally done but I think when you are doing things like a master's degree it does take a lot of work and some things do have to be pushed to one side. But, you know, my children, you know, they're quite honest would tell me that they don't feel that that's been the case. But I think "from my husband's perspective he's found it quite difficult, the fact that I'm continuing to study".* Anna 27 UK

> *"He had his full-time job and at night, because I was sitting with my books. That was a problem for him, because he always said, "you only have time for your books". When I finished my study the marriage was over".* Rebecca 21 SA

> *"I remember there being a bit of an argument one day. I remember kicking the washing basket downstairs because I'd asked him to put the washing machine on while I printed my dissertation out".* Helen 33 UK

A minority of women had experienced some resentment. This was at expressed at various levels ranging from disagreements, anger, mental and physical abuse or/and violence and/or partners stopping them from undertaking PPD.

> *"My husband will always be threatened by me because he's not as academically inclined, or financially stable as I am. So for him he'll always be threatened in a way".*

> Mandisa 23 SA*"My husband felt a bit inferior, because here his wife is moving … Men overall, feel a bit threatened when their wives earn a bit more, achieves a bit more, because males feel they are supposed to be the breadwinners".*

> Charlotte 9 SA*"He was supposed to understand because I'm not doing this for myself, I'd be doing this for the family. And you know I earned almost 10 times more than I earned when I was working in the clothing".* Mary 11 SA

> *"That is actually bringing you down emotionally … it gets you down. Because you are really trying, and no one understands now … They're not going to understand when I say I can't because my husband is angry".* Charlotte 9 SA

Three **SA** women spoke of their other friends who had partners who would not allow them to engage in any PPD activities. They were black SA men feeling threatened by women gaining greater status by becoming educated and getting better jobs and pay, gaining a higher status than themselves.

> *"Some of them wanted to be on the programme, but their husbands warned them our life is not going to be the same, and now when they're faced with the problem of not having … the children want things and whatever, the husband is not that supportive because they must still go home, then they must cook and they must do all those things and whatever".* Esona 14 SA

Exhaustion from working and studying at the same time: As previously noted, many WRNs were working whilst continuing to undertake full responsibilities in the home. This included women who were single. Some were caring for children, and then had to study late in the evenings, and into the night. These constraints resulted in them not studying at the best times, and not producing the best quality work, which could lead to stress and failure, with the knock-on effect of having to pay additional fees for re-sitting exams and essays.

Giving up annual leave and holidays to study was also described:*"When I finished it I'd lost weight and I had really become a couch potato".* Anna 27 UK

"It was tiring. It was very tiring. Very sort of stressful". Danielle 46 UK

"The manager did not want it to use my leave to write exams. So I said, 'But this is my leave, it is my annual leave and you cannot dictate to me what I do in my annual leave' and she left it at that". Rebecca 21 SA

"Sometimes you're too tired to study on your day off, you'll probably sleep". April 1 UK

A few women from both countries said that to cope with work/study they found themselves having to take breaks, otherwise they would not have completed their studies.

> *"I was exhausted by the end of it because trying to do a full time course with a full time job and four children was very difficult and I think if I hadn't taken the six months*

> *out I probably would have given up so it's given me just some time to get a breather".* Eleanor 30 UK

Examples of the categories of hidden costs relating to employers, line managers and work included the following:

Negative behaviours: Negative behaviours often stemmed from issues within the work area, for example, short staffing which consequently affected team members and those who were taking steps to develop themselves. Several women said they had experienced negative comments and behaviours from other women about their PPD activities. This resulted in them having less, or no support from work colleagues. Several women also said they could not have anticipated the negative behaviours which made them feel they were being treated as if they were a threat. Nor could these women when coming up against these negative behaviours predict the effect it had on them personally. Several WRNs left their employer because of the lack of support such as Rebecca:

"I asked for a bit of study leave and I was told, I needed to work five years. Yes, I need to work five years post-registration, before I can then do this. So, with the result, I left, because I couldn't wait five year". Rebecca 21 SA

Below is an example from Karen, who spoke about a work colleague's behaviour:

"If I was off for the day on a … doing my stuff she would make me feel guilty

> *… I wasn't happy there so I asked to be moved so I moved wards".* Karen 35
>
> *UK*

"She's not very, very, supportive. Not interested… I don't talk a lot about my studies, you know. I keep a very low profile. It's much easier". Khahula 19 SA.

SA women spoke about their shifts and annual leave requests being cancelled by their line mangers, resulting in conflict between them.

"When you book leave you're not getting it". Bukeka 7 SA

Professional jealousy: This **SA** term was used to describe other women's behaviours and attitudes towards those who had taken opportunities to undertake PPD activities. Examples included accusations that it was unfair, questioning why an individual had gained support for PPD activities and/or was undertaking PPD activities while others in the team were not, even if they had not applied or shown interest in undertaking these PPD activities themselves. Women in the **UK** also gave similar examples of colleagues' negative attitudes towards them undertaking PPD activities, although they did not use the term professional jealousy. Professional jealousy was discovered to be a very different form of behaviour than other negative behaviours, as the reasoning behind these behaviours differed. Negative behaviours often stemmed from issues within the work area, for example, short staffing which consequently affected team members and those who were taking steps to develop themselves. Professional jealously appeared to be the way in which others in the team not undertaking PPD activities reacted to the situation or event.

> *"I had to be a week on a workshop, I had to inform them … but then I had to inform the others as well, because I am not the only one in the team, and there was a bit of professional jealousy from my work colleagues".* Esona 14 SA

Line management and PPD: Several WRNs believed the appraisal process was to support development. They did not anticipate the range of emotions that they felt from having been told there was no offer of support. Women's emotions ranged from frustration, despair, apathy, to anger. This is turn changed their attitude towards working for their manager and their experience of working for the employer.

The attitude of management, and the lack of funds in the PPD budget, resulted in frustration for RNs. The management and conduct of appraisals

could swing both ways with regards to PPD and for many participants it resulted in confirmation by line managers that they could offer no support.

Managers are expected to adhere to employer's work policies. Angela 12 a **SA** WRN who worked in the private sector said that she had "came to tell me about her employer's policy", as she believed quite strongly that "people should know" how **SA** RNs were treated by their employer. Explaining that if an RN went off sick, and happened to be studying on a course, they would immediately be expected to see the manager for a review meeting. However, if an RN went off sick and was not studying on a course, then they were not called to see the manager. She perceived this as unfair and unsupportive practice, with no proof that suggested RNs were off sick because they needed to study. That her private employer's process/policy was used to threaten employees, if they were not coping with both work and study, employers would take further action to address this for example by advising them to cancel their studies, as work took priority. This was confirmed by another SA RN who also worked in the private sector and claimed that it was known that some RNs used sick time to carry out other things such a study, private employers introduce a policy to stop RNs studying on courses if they had sick leave.

> *"Everybody who is going to start has to sign forms for the study leave … because what they do, I think they were exposed … before the nurses started doing their own thing they don't come to work … they call you if you've got this pattern, now of which you starting … so what we going to do, we going to cut this thing of yours for studying because it is affecting us".* Sisa 43 SA

Several line managers did not encourage the nurses to develop personally or professionally. Women said that their line mangers' behaviour towards them changed once they had disclosed that they wished to develop further.

> *"People they don't want to move you on, either because they always worry that if you go then there's nobody to*

> *take your place. …All about people who don't want to*
>
> *pay you; it's all about - you know that's what it boils down".* Nesiwe 24 SA

Bukeka 7 SA spoke about the angry confrontations between herself and her line manager about her development. She felt that the relationship had broken down and that she had to leave the workplace:

> *"What we end up doing in the situation, because you can't stand for ten years and you're waiting for the study leave. And you also have your family to plan for, you have life to plan for, and you are still waiting for the study … and all the letters that you write every time is rejection, rejecting, and then what can I do then, because I wanted to go this thing in the right route, but now I must end up doing it in the wrong way".* Bukeka 7 SA

Line managers in **SA** were found to behave in a far more autocratic and hierarchical leadership style that could not be questioned by sub-ordinates. **UK** managers still had a hierarchical leadership style, but allowed questioning about budgets and funding.

Time: Several women in the study did not anticipate the amount of time that they would have to spend when undertaking academic study outside of paid working time. Unanticipated effects of not finishing work on time was raised frequently by **UK** nurses, and those **SA** RNs working in rural areas of which they had a high number of patients and very few doctors. This had a knock-on effect, creating less time to study outside working hours as other responsibilities inside the home still needed to be met and it had an effect on relationships with friends, family and on important social events.

> *"You always had free time when you worked before, and now suddenly you are preoccupied with books, and you can't. So every time when there's a birthday, or something coming up and you know, then you always have to excuse yourself and say, but sorry I'm writing*

> *on Monday. So they were very understanding, you know".* Esona 14 SA

Guilty mothers: Many women spoke of feeling guilty about the effects their PPD had on their children. Often referring to the reduction in the time spent with them and for others it was about the lack of monies they had as a family because some of money had to be used to support payment for PPD activities. Other women spoke of feeling guilty when using family monies to pay for PPD activities.

> *"I really want to finish it and we would probably find a way. I don't know how but it's a lot of money and, you know, with having four children there's still many other things that are priorities at the moment so … and it's a guilt thing as well. You're kind of thinking should I really take that money for myself to pay for this when I could really do with this and this for the family".* Eleanor 30 UK

"Not Academic": Many women viewed themselves as not being academic and did not rate their academic skills highly which added to the hidden costs of PPD. This was regardless of whether or not they had confirmation from previous academic work about their level of academic ability. Their academic levels varied and they struggled to study and write. Even so some women were put into a position where they had little choice but to undertake PPD activities and to pass assessments, as stipulated by their employers. Several **SA** women struggled because English was not their first language.

"I find very, very hard because you know for me I am a hands on person". Mandisa 23 SA

> *"They've been trained in things that I wasn't. So it's maybe more of a factor that I haven't had that academic background. It makes me have to work harder, put in more time which is valuable already".* May 3 UK

Competent nurses, unconfident in IT and academic skills: Several women over the age of 40 (or more) years old from **SA** and the **UK** argued that their struggle to undertake PPD was doubled, in comparison to nurses who had grown up using computers and writing at academic level, because of the lack of skills which they needed to learn. Some women paid others to type up essays, whilst others paid to undertake IT courses.

"I had to teach myself…I had to teach myself computer skills…Because it's not the stuff that you were exposed to. It's not the stuff that you needed to do… You're busy as a mother, with other things". Zika 41 SA

"Didn't have computer skills … Didn't have internet access … Paid for the secretary at work at the day hospital to email all my stuff …. Paid to do a computer course… Brought a computer with the NRF funding … Neighbour is IT literate … I go and ask her and she assists me". Rebecca 21 SA

Proof reading and checking essays: Several women from both **SA** and the **UK** found it difficult and were not skilled at proof reading and checking their own essays. Others had experienced failure and it took confidence to ask for help from others as it exposed their personal weaknesses, which they were not accustomed to. Several of these women were employed at highly graded jobs and saw it as risky to admit to the RNs they line managed that they were finding it difficult.

Writing essays when English is not the individual's first language: Several women from **SA** noted they found it difficult to write in English, and that it took much longer for them to do than for those who had English as their first language[23].

"Because you're still analysing the question, and you're still building the answer. You see what happens when it's not in your language". Wazini 40 SA

[23] There were no WRNs in the UK that spoke of English not being their first language.

Time outside of paid working hours: Working shifts and studying around family and other commitments often resulted in women not studying in the most effective way and not at a time in which they could be most productive or produce good quality work, which put them at risk of producing poor work that may not meet the standards required. Women had limited opportunities to undertake study outside of paid working hours.

Space to study: Women found it difficult to find space to study at home and within paid working hours. Children and other family members often had higher priority over space in the home for carrying out their study and using computers/internet, than the women.

Travelling to and from places of study: Financial costs towards travel to study in different places were also incurred. In **SA** WRNs had to choose times that were deemed to be the safest time to be in places, and to avoiding travelling at night or travelling through places at times that were known to be unsafe for women.

Isolation: the "lone soldier": Some women such as Amy 28 UK found themselves as the only one undertaking study, with no peer group. This was regardless of whether they lived alone or shared accommodation with others. This appeared to be common at Masters' degree level, and this loneliness was compounded if they received little interest or support from colleagues at work.

"It's difficult on my own". Charlotte 9 SA

"It's just that sometimes I did feel very isolated because it seemed to be that there was only me doing it…I was kind of on my own". Helen 33 UK

Withdrawing from social and family activities: As women's commitment toward their PPD activities took up much of their unpaid time, they found it difficult to continue to be able to access these support networks. Some spoke

about losing contact with friends, who did not understand the level of commitment involved.

"I then lost a lot of friends, because I spent a lot of time, you know, with distant value, focusing on my studies". Rebecca 21 SA

This first sub-theme (Hidden Costs of PPD) emphasised in depth the costs, some of which were unanticipated and perceived as hidden, that made it difficult for women to be successful in engaging in PPD activities. It highlights the stress that women experienced and some of the barriers they faced. This led to the findings that revealed the strategies used by the women to overcome their difficulties and the rationale behind them.

5.2.2 Strategies and techniques that women used to overcome the difficulties – 2nd sub-theme

WRNs from **both countries** experienced and perceived the hidden costs of PPD, which affected the management of themselves and of their lives outside paid work. Women found different ways to manage their PPD. They used techniques that were effective in approaching the many tasks, and strategies that involved using methods they found worked for them and they made plans that helped them achieve their aims and goals. Many women would not commence PPD unless they felt they, and their families, were prepared. They weighed up their current situation and circumstances and aimed to counterbalance the stresses and strains of personal study and their family's lives. Some women used their judgement to decide whether the time to undertake PPD activities was "the right or wrong time". Without the assurance of balance within their lives, of having family members organised, and of themselves being mentally prepared, women were unwilling to engage in PPD. They also needed clarification there was space and time to be able to study in the home and outside of paid working hours. Women were unwilling to engage in PPD activities involving academic studies, without having assurance of the balance needed at home and at work. Hence,

planning and achieving life balance was important before during and after PPD activities.

"I don't want to push myself too hard … Burn myself out. I don't want to get really stressed … I don't want to tip it". Danielle 46 UK

Employers, line managers and work: The strategies women used to counterbalance issues regarding employers, line managers and work ranged from being prepared to seek opportunities to using strategies that resulted in the least amount of conflict, such as "moving silently" so that no one would notice or know what they were doing.

White **SA** women facing threat of no future employability: As previously noted, one **SA** woman (Khuhala 19 SA) was taking action to undertake further PPD activities and qualifications to increase her chances of success in job applications. Gaining further qualifications would stand her in good stead and help her to manage the threat of possible re-structuring which might mean her having to re-apply for her job. The restructuring would be due to accommodating the BBE (2016) rules of positive discrimination towards black and coloured people previously mentioned.

Making the choice as to which employing organisation to work for that will support RNs' PPD and careers: Women showed awareness of who was the best employer to work for in relation to support for PPD. This awareness contributed to their strategy of listening to other's comments and were proactive in researching information on the employer and information on the speciality they wished to work in. Some women waited to move jobs, when they judged the "time was right" for them and their families (for example Anna 27 UK and April 3 UK). Several women moved geographical location to further the opportunities of PPD which in turn they hoped would lead to better pay in the future which was more common in **SA women than UK** women (for example Angela 12 SA).

"Quiet time" during paid working hours: Depending on the type of job, only two women were able to find quiet periods at work when they could study. They took their study books into work on a daily basis. Others used their mobile phones, 1 **UK** woman who worked on the ward and in the community took a dongle and laptop into work so she could access the internet wherever she was. In **SA** all WRNs had a mobile phone and could access the internet, those in rural areas spoke of having to travel for up to 1 hour to get better internet access at an internet cafe. 1 **UK** woman who lived in a rural area struggled to get any internet connection, so had to use the library. Using the library to use computers and free internet was common for **SA** women who lived close to University.

"I have it all on Google Drive … so I can access everything … it just meant that I can get an hour". Karen 35 UK

Access to PPD time: Women from **both countries** were found to use flexible shift patterns to meet the needs of their PPD, to be able to attend taught sessions, and to undertake study outside of paid working hours, hence attempting to avoid the use of annual leave, though not always succeeding.

"Be able to double up shifts gives you an extra day". Amy 28 UK

Natalie 36 UK studied for her degree in her own time, attending lectures during the weekdays and working at the weekends. However her manager told her that she could no longer support this because other staff had complained because they were not able to work so many weekends and viewed Natalie as earning more money than them.

"The manager told me because you're working to many weekends and they can't do weekends because you're working them, Regardless that you were doing your degree at the time". Natalie 36 UK

Line managers, appraisals and PPD: Several women did not wait for yearly appraisal meetings with their line managers to discuss PPD, because they did not want to miss opportunities. They researched the requirements and

organised themselves to be able to undertake PPD activities. They approached their line managers to arrange informal meetings, asking for support and presenting the details and/or funding options to their line managers for consideration.

> *"I sort of had to barge my way in for that because I liked it and I'm interested in it and I really liked it and I thought - right well I want to know more about that but then you had to go and shout and say I want to go on that course".* Emily 34 UK

"One off" technique: Women in **both SA and the UK** had to work hard to overcome negative behaviours from their families, by saying it was a "one off" event so that they could undertake some study for a course/qualification. This was an effective way of gaining support in different ways from their family and friends. Five WRNS from **both SA and the UK** held a family meeting so that there would be a group agreement. They delegated household tasks and the normal caring responsibilities to members of their families whilst they undertook their studies (see below for examples).

> *"I said 'right we're going to have to … I can't do everything any more so right, what are you going to do? What are you going to do and what are you going to do?' So that's how we did it and, you know, helping to prepare meals, dishes, whatever helps".* June 4 UK

"People have helped me like my mum will come and do my ironing and sort of like". Esther 31 UK

Some women extended this "one off" event, explaining to their families that now they had travelled so far in their studies, they needed to continue to study to gain the whole qualification. Hence, they continued to ask for support from their families.

"When they were younger we had family meetings … Task list… Got a dishwasher, I cook when I feel like it and the rest of the time, I say … sort themselves out. I make sure that there is enough food in the fridge... They do help around". Rebecca 21 SA

Positive space to study: Women found ways of studying outside paid working hours. Some relied on their friends and family members who offered access to space in their homes, so that they could study without distraction. Others travelled to university or hospital libraries to study, without distraction from the family. One woman paid for accommodation at a university campus over a weekend so that she could get her work done. The support women wanted in relation to childcare responsibilities was "space to study without distractions" in or outside of the family home, in a chosen space, and often away from the children. To avoid being distracted they would request that their partner, family or friends take the children away from the home and entertain them, for an agreed length of time during the day.

"He just goes out and leaves me to it … He lets me have the house to myself, peace and quiet". Emily 34 UK

"The library is 24hrs opening time, so you can study there all night". Wazini 41 SA

"He used to take the kids out to give me that time to study in peace and quiet". Natalie 36 UK

Other women took the other option to leave the family home so that they could study elsewhere. They found that by studying at home they would get distracted by undertaking housework. Some women were also able to access help with childcare at the same time.

"At the weekends I get a couple of hours, go to college or something when there's somebody to look after the baby". Karen 35 UK

> *"Monday I went to a friend's and she offered me her dining room and I got so much done because I was there for a purpose. I wasn't there to answer the door or do anything else. I was just in a dining room and I got loads done"*. Anna 27 UK

> *"She'll quite often say just come round here, and leave him … she's got quite a nice little workstation in the attic and I don't know why, but I seem to get most of my best work done there".* Danielle 46 UK

Getting support with IT: Three women undertook PPD activities at the hospital or university libraries so that when needed, they could seek and receive support with IT.

"I'm not an IT person, not at all … the Librarian can help me". April 3 UK

"At the hospital in the library … lot of meetings there to go through your assignments and things". Natalie 36 UK

"Have to use the library as I can't afford a computer". Charlotte 9 SA

Silent movement of women's PPD: This pattern of silence was observed within the workplace, away from the workplace and in social settings and within the home whereby women had chosen not to tell they were undertaking PPD. Two women could no longer remain silent and not be seen or for others to know they were engaging in PPD activities, and they found themselves in a position in which they had to declare that they were undertaking PPD activities.

Within the work environment, women chose to undertake PPD without telling others around them, hence the "silent movement". Many chose not to tell their employers or line managers, others chose not to tell any of their team members, others told just one or two members of their team who were sworn to secrecy. Several women only told a few trusted members of their families and/or friends. This was more common with **SA women, than with UK** women who spoke of professional jealously and negative behaviours within the workplace.

> *"I think that it is professional jealousy. So I've learnt, you rather keep quiet … some other people would say … how can you come in here the other day and you want to finish? … Why would you get sabbatical? … You know, and so I have learnt over the years, you don't discuss your story".* Rebecca 21 SA

A minority of the **SA** women did obtain funding from their employers – these women were on the specialist grade and had to complete their programme of

study within the set time-period (out of the three women, they did not receive funding to pay for accommodation or other expenses such as travel), whereas the majority were self-funding. For some women from **both countries**, this strategy of being silent resulted in minimal resistance from others and was because they did not want to "rock the boat" between other team members or to be oppressed by others. These women wanted to have control and ownership of organising themselves and studying at their own pace without anyone else's input. If they failed, then they did not need to tell anyone about it, and no one could use this knowledge against them. Meanwhile they wanted to prove to themselves they could do it: if they were successful in their PPD then they could use this (if they wished) to prove to others that they had done it. Many women resisted the oppression that they felt they were having to fight, so that they could develop themselves. This "silent movement" was effective in achieving their ambitions.

Choosing not to tell others about their PPD activities for differing reasons: In relation to women in the work environment there was a variety of reasons given from wanting to "have a go", to avoid pressure, judgement and/or negative behaviours from others. Other reasons included a lack of confidence or viewing themselves as "not academic". Not telling line managers was because the women perceived them to be unsupportive and likely to threaten not to give permission to carry out their PPD activities, or be obstructive by organising working hours and annual leave so that the women missed lectures, exams and time to study to meet deadlines. The **SA** women perceived that their line managers may "try to stop them" due to professional jealousy and/or that of other team members.

SA findings showed there was a conflict with line managers wanting to control the study leave women wanted to take. Several women made the decision to undertake study in their annual leave time. Three **SA** women had found that their line managers attempted to stop this by saying that either they could not study or by attempting to cancel their leave. For example

Esona decided that she would no longer request study leave as this was cancelled by her line manager:

> *"There's a list out that you have to put leave on. So then I saw that leave was on there and saw my name was scratched out, and I asked - Why did you scratch my name out? So she said that but you guys must actually apply for study leave, because it makes it difficult now, everyone wants leave at that time now … I just told them - I'm sorry, but I'm not going to stand back, that's how I feel about professional development. I'm not going to stand back, I've waited so long to do things and you guys having working here for, you know, for 15 years, 12 years in this same ward … now suddenly you're like, you can also do it like that. So I just told them that I'm going to my union, and it needs to be changed by the end of the day. So I told her I don't owe you any answers because this is my leave, so I don't need to explain to you what I'm going to do in my leave time".* Esona 14 SA

PPD activities 'a private affair': Several women took the attitude that if their employers would not offer to support them by not providing funding to meet their financial costs or study leave and time at work to study, then they perceived their PPD activities as their own private business, carried out at home needing no one else to be involved. Thus, they remained silent about their PPD activities.

> *"I didn't even write a letter informing them that I'm studying, because I thought for me why I must inform them, because I don't have study leave. I don't want anything from them because I'll be using own leave now".* Akua 6 SA

PPD activities out of sight in the work place: To maintain their secret cover, several **SA** women did not always claim study time or the exam day **(SA only)** that they were entitled to, because it would mean they would need to disclose they were studying. Three women, this was due to past negative experiences with their line managers, team members and their employer.

"She's not very, very, supportive. Not interested… I don't talk a lot about my studies, you know. I keep a very low profile. It's much easier". Khahula 19 SA.

PPD activities out of sight in the home: Further examination of the data identified that three women from **both countries** used this this silent movement strategy in the home, studying at home when their partners were working shifts, and at night when everyone else was asleep. Again, women were resisting forms of oppression by studying out of sight from their partners. Their partners had no idea if or how much time they spent studying.

"Most of my studying I do at night, so everyone sleeps". Mandisa 23 SA

No longer silent and no longer out of sight, having to declare PPD engagement to the line manager: Three **SA** women found that they had to tell or declare to their employers that they were undertaking study, no **UK** women spoke doing this. **SA** women said this had happened when they were close to completing their studies, so they did not face further barriers to complete their studies. Reasons to declare they were undertaking study were: they needed to have practice hours signed off by / consent from the line manager as part of the university's study course; they wanted to request study leave and/or the exam day; they needed to request to work certain shift hours so that they could attend study classes or sit exams, and they wished to apply for other jobs which required a reference from the line manager, who otherwise had no knowledge of their PPD achievements.

Studying, making the choice as to which employing organisation to work for that will support RN's PPD and career development: Several women moved from their homes to bigger cities to undertake PPD and work for an employer that had better support for PPD and/or universities with a good reputation. The costs were financial and emotional: re-location costs, travel costs to return home to visit families and friends, payments to family and friends for cleaning, housing/ rental, paying for the care of elderly relatives, childcare, and boarding fees. Emotional costs including the stress of leaving family and

friends behind to study and work at a location far away from home also needed to be taken into account. Other women had taken a pay cut to move to new employers and jobs in order to gain better support for PPD activities and career development opportunities (distance often being far greater for **SA** women such as 3 days bus travel for they could not afford air travel).

> Others used it as a strategy to remain employable in an unpredictable work culture.*"When we did get made redundant from the ward I was really glad that I had carried on with this because I knew that for any interviews that I went for and any applications I could put in and say well I've got the degree and I'm working on the Masters, could only benefit me. Now whether it made any difference to the job I've got I've no idea and I know a lot of people went for the job that I've got".* Amy 28 UK
>
> *"When initially when I did the degree you had a bit more of an edge on some of the people that did the diploma and I thought maybe it would give me – because I'd had so much time out with my maternity leave, if I was looking for a new job it would give me just a little bit of something more".* Eleanor 30 UK

Charlotte 9 SA felt that as a result of not receiving any development opportunities that she had thought *"I just stood there once and told myself - I'm going nowhere".* The action she took was to leave the employer, change jobs and access better development opportunities with her new employer.

She also *"took a major salary cut back from where I was to here".* Charlotte 9 SAIt was evident that several women had decided to leave their employer and find new jobs with a new employer who offered better support for PPD.

Several **SA** women had relocated from the Eastern Cape to Western Cape to carry out PPD and gain a job afterwards, offering better employment opportunities than in the Eastern Cape. Because of the long drive being on average 3 days this was too far to travel home on a regular basis. Several women spoke of having to pay money to people to provide care for members

of their family who still lived back at home (Eastern Cape) and how that was stressful in many ways.

"My mother is in Eastern Cape, I must still give money. Ja, because I am the eldest one looking after my mother". Anita 45 SA

"Pay for a career and cleaner to look after my father …. Hospital accommodation doesn't allow children to stay overnight …. Having to pay boarding school fees". Sisa 43 SA

"I moved from Durban to Cape Town, because of the … of the speciality … difficulties in relocation, parents are old and elderly unable to care for them as she lives so far away. I get upset about it". Angela 12 SA

For some women like Sisa above, who had recently qualified and been unable to find jobs in the Eastern Cape where there were high levels of unemployment, their strategy was that whilst unemployed they moved to an area and an employer who was more supportive of PPD.

For several women recently qualified and struggling to find permanent jobs, their strategy was to use this time wisely to study for a higher qualification, which they thought would aid their employability. Other women were studying for a higher qualification whilst they had the time to do so. In the **UK** women spoke of travelling to work or study taking 1-2 hours to drive. None of them spoke of travelling any further distances.

"I thought to myself, I'm in my early 30's, not married, not got children, let's go for it now rather than try and do something later on". Helen 33 UK

Using "sick time" to recover: Several women from **both countries** (more commonly **SA** women) found themselves feeling exhausted from work and under stress, they were unable to complete their PPD studies because of this stress and exhaustion. Reluctantly two women said they had to take sick leave to recover. One said that she would have to take off sick, if she needed to complete PPD work by the set deadlines. This was the only way they could manage reducing the risk of failure. They felt that they had no choice

but to do otherwise. These women had not received any support, and hence no consideration of their careers/PPD by their employers.

"If it comes to that, and I must do it. I must take a Benylin [SIC] day to complete … because my studies come first now". Grace 39 SA

"It was not my plan, but because of the circumstances that I'm currently in I have to do it like that. It's not feeling right for yourself, but at the same time in order for you to achieved, what you want to do". Bukeka 7 SA

Resisting negative behaviours from partners: One **UK** woman said her husband did not support her PPD activities, and that he did not want her to do them. As a consequence, her strategy was to study when he was not in the home, and to hide any evidence of her PPD activities. Another woman spoke of studying at night with just a candle lit, so that her partner would not know that she was studying. **SA women** reported this more frequently than **UK** women whereby it was common in black **SA** communities for women to face resistance from men who felt threatened if women tried to educate themselves.

"I would put up a candle and study, so that you can't see the light is on". Mary 11 SA

"Tidy house, tidy mind": Women from **both countries** said that they needed to have a "tidy house", and only then were they able to concentrate on their studying. Many women held the main responsibility for housework to be able to study at home. Women were found to have accessed support from other family members and friends who offered to help with housework (paid or unpaid), and this extended to help for some with childcare too. Several women also paid others to undertake cleaning and housework duties in their homes. Some of these housework duties were seen as favours carried out by friends, to be repaid at a later stage, hence an invisible hidden cost of PPD.

"I think, for me, it's like tidy house, tidy mind so they will say 'why are you cleaning the house when you've got studying to do?' but to me, if I can get …

but I've cleaned all downstairs now so now, later on today, I will crack on and get some done". Anna 27 UK

"Family, really supported me in quite a lot of practical thing … household tasks". Julie 44 SA

"Lady that comes in, just to assist me, you know with my ironing and stuff like that, it actually helps". Rebecca 21 SA

Best time to study: Some **UK** women said the best time to study was in the morning before they started late shifts or on their days off from work. For those who lived with others, it was when "everyone was out of the house", and this was when they had the best levels of concentration. For several women in both the **UK and SA** their only option they could describe as a strategy was to study at night.

"At night when it's quiet, children are sleeping". Anita 45 SA

Having support from others was an effective strategy used by women.

Studying with their children: For several women from **both countries** who had children, they studied within the same time periods in the home as their children did. This led to supporting each other in their studies.

"In fact in some respects it's helped them when they see their mum studying to get on and do their studying". Anna 27 UK

Mother-daughter relationships in supporting PPD: Women from **both countries** often turned to their mothers for support. Mothers supported their daughters' PPD by offering emotional support – a listening ear, providing them with space to study, doing housework and undertaking childcare to allow them to undertake their PPD activities. This was one the most commonly repeated categories within the whole study. **SA** WRNs work 12 hour shifts and therefore needed their children to be dropped off and picked up after school. Two **SA** women in the Eastern Cape left their mothers to care for their children.

> *"My mother. Yes, although she's not well educated, but she was willing me, always willing. Sometimes when I'm short of money, she's a pensioner mos [SIC], she tried to send me money from Eastern Cape to buy me a ticket. She encouraged me a lot to study further, even*

the family gave me support, even now". Anita 45 SA*"She will and she'll talk to me and she'll talk it through".* Karen 35 UK

> *"My mother also, always encouraged me… My mum, she's also doing teaching part time. She's already a pensioner, but they always ask her to work, so my daughter, the one of 7 years old, she stays with her during the week to get her ready for school. The weekends they stay with their dad".* Grace 39 SA

"I've got my mum – she's doing my ironing … she would look after the kids and them for a couple of nights so I could get some work done". Natalie 36

> *"She's the king pin for everything … you know she's never studied really, but she's always been very supportive of us, and she's just there you know, for everything … She picks my sons up … When I come over supper's made, things like that*". Mandisa 23 SA

Supportive attitudes and behaviours: Several women from **both countries** had supportive partners and family members and friends who took on various degrees of responsibility for childcare and housework that the women themselves would have normally undertaken. This allowed them to focus on their PPD studies. This support also included financial support.

"Support from my husband, my in-laws from my mother, because if I couldn't do this for my son, then they would be there ...I had a very good support system". Zika 41 SA

"Family, friends, my mom, other church people. Not only emotionally but also financially. So I mean without finances you can also you know, not do it". Mary 11 SA
"He was helping me a lot if I make decisions regarding my work, or whatever I do. He's very handy in the kitchen. Childcare: when he is on his day off". Laura 16 SA

Children supporting mum's PPD: Several women from **both countries** talked about asking their children for help with IT skills, computer programmes and

proof reading their work. Some children supported and encouraged their mothers to study.

"My undergraduate studies were not computer based … I had a teenage daughter who helped, who showed me how … Really supported me in quite a lot of practical things". Julie 44. SA

"Just keeping up to date with me "how you getting on?"… and …have you got your mark back?" And just knowing that they're there supporting me, knowing that I could carry on". Amy 28 UK

Support in studying: Female friendships formed when studying on the same programmes/courses. Women **from both countries** met up with each other in their homes, and within their workplaces. They also used mobile phone technology and set up internet Facebook groups, to communicate and to offer support to one another, often in peer student groups. Several continued to keep in touch with these friends when undertaking further PPD activities as they continued to offer support and advice. Others had friends who were nurses and wished to support them.

"The people I did my degree with have supported each other. That was really good … we did use Facebook a lot … I'm still in touch with one now after the course has finished". Danielle 46 UK

"They phone me they ask what I'm doing … they also want to come and help". Sisa 43 SA

"When you're struggling or you're kind of making a fool of yourself really, which I did at one point but, it's nice if you can go to somebody and they'll say 'oh I'm finding it hard as well". May 3 UK

"Some of my colleagues and they have also phone me to ask how are things going? How is that? We pray for you … and my unit manager". Grace 39 SA

Another woman commented that she did not gain from the on-line learning groups, but that instead she found it more beneficial to meet face to face with her peers to talk about their studies.

"I didn't like it. I don't think I got the support …. Communicating and seeing whether you're actually on the right lines. … Because we lived locally and

that so somebody's house or at the hospital, in the library". Natalie 36 UK
Proof reading, computer use, typing up essays and checking essays: Several women from **both countries** gained the confidence to ask for help, and admitted that they needed help. Women asked for support from family and friends in doing these tasks.

"Didn't have computer skills … Didn't have internet access … Paid for the secretary at work at the day hospital to email all my stuff". Rebecca 21 SA

"He proof reads …tends to pick up on my grammar and punctuation which I find helpful". Eleanor 30 UK

"He was good. Typed my assignments. He helped a lot by doing research. Sometimes I didn't get access, I couldn't get access for some things, and then he would go to work, make copies for me on the computer". Esona 14 SA

This sub-theme 5.2.2 has detailed the range of strategies and techniques women used, so they could engage in PPD activities especially when having to study outside paid work hours. They also chose to study modules that would be funded by the employer (**UK only as the SA** only permits study for a whole programme). One **UK** RN was taking an academic course with agreed funding from their employer that could be studied module by module. She did not choose her modules according to her interests for if she had the employer would not have provided funding (this modular system is not used in **SA**).

"I picked modules that related to my practice so that I didn't have to pay for it". Jane 29 UK

Recording PPD activities and using them to apply for or demonstrate evidence for bonuses schemes (**SA only**) was a strategy used by several WRNs to fund the next stage of academic studies.

"I spent my bonuses on that and I was able then to achieve what I set out to achieve". Rebecca 21 SA

To summarise Main Theme 3 (The Hidden costs of PPD and the strategies and techniques women from **both countries** used to overcome the

difficulties) focused explicitly and in greater depth on the hidden costs of PPD activities (described in sub-theme 1). These hidden costs were stressful, emotionally and physically demanding, financially draining and very time consuming. Only a small minority of women were positive about the support they received from their employer in the form of funding and time to study; the majority were negative. The approach in this study was to look at what was personal to women and "not to sweep this under the carpet" as insignificant. In women's lives, these costs are very real and the penalties can be failure, ill health, financial burden or the breakdown of a marriage/relationship.

The research revealed a collection of effective strategies and techniques that women used to overcome their difficulties (sub-theme 2). However, this does not imply all women used them. Some women discovered them by talking to other women about their difficulties and seeking support from others. The reasons behind their choice and use of their techniques and strategies could be complex: for example, women who "moved silently" in their PPD activities had a number of reasons for adopting this strategy such as not wanting to tell others as it was their private business. By doing this, employers, managers or anyone else had no power or control over them, they avoided conflict with partners by not undertaking study when they were in the home and/or ensured they had no knowledge they were studying and therefore could not stop them from doing what they wanted to do.

For those who had little money and no access to support for their academic studies they had family and friends to show them how to use computers, proof read their work, to listen and help problem solve, to help with household responsibilities including childcare. Many women said that without having a "tidy house" they could not concentrate on their studies, they were too distracted because this was extremely important to them.

Phoning in sick was a technique used with much reluctance, for women found themselves exhausted and they needed time to recover. Others said they needed to do this so they had time to focus on study. As employers offered little or no study time, the threat of financial and other consequences such as failure left women feeling that they had no other choice.

Theme 3 successfully raised issues that were important to women throwing light on some of the reasons as to why strategies and techniques were used, and the reason why this was so.

5.3 Women's PPD journeys – Main Theme 4

This main theme 4 derived from the knowledge gained from the core and other main themes identified in the research to explore the patterns and relationships within PPD for WRNs from **both countries**. What came to light was a greater understanding of women's journeys with regards to their PPD. By looking at the patterns of women's journeys, it was possible to build an overall picture of what these journeys looked like, why these journeys could differ from each other and what influenced or affected women's PPD within nursing today in both SA and the UK.

The three sub-themes of Theme 4 are: The pace of the PPD journey, women controlling and managing their PPD journeys, and unplanned and planned career approaches. Findings in this theme confirm that women have been moving at different paces within their PPD journeys. Previous themes identified sub-themes that influenced women's PPD journeys. These include women's perception of PPD once they had qualified and the level of engagement, they undertook in PPD activities, the individual's personal and professional aspirations, and their individual circumstances.

These sub-themes brought about recognition that women perceived they undertook an unplanned and/or a planned career approach within their PPD journeys. Women during their careers could switch from an unplanned to a planned career approach, and vice versa. This made women's PPD journeys

in nursing not so straight forward, compared to what is considered to be horizontal progression within a standard career ladder or framework.

Theme 4 challenges any assumptions that women are rigid within their careers by either taking a planned or unplanned career approach. These assumptions are made by frontline RNs, managers and employers.

Findings have shown the complexity of women's lives and their decision-making around engaging in PPD, demonstrating they can stop and change their career directions at any point during their working lives. Some of these sub-themes revisit data that have been previously identified within previous categories but are applicable within the context of the current theme including: Embracing PPD rejected by service needs, Fragmented funding, Supporting nurses in different ways and not supporting them, access to time for PPD activities, Fragmented time, "Not academic", White SA women under threat of future employability.

5.3.1 The Pace of the PPD Journey – 1st sub-theme

Women moved at different paces within their PPD journeys. The following categories were identified: (a) Once qualified - moving at a slow pace. (b) Starting, moving and keeping going. (c) Moving and slowing down – what stops women from moving at their preferred pace? (d) Delay in moving or starting their PPD journey - this also included the identification of personal categories related to individual and financial support. (e) Stopping on their journey - women perceived to be "standing still". (f) Once qualified, moving as fast as they could - until they had perceived that they may have to stop or slow down. (g) Moving fast – women had different reasons for this. (h) Slowing down on their journey having carried out a great deal of PPD.

Once registered/qualified - moving at a slow pace: Several women had no planned career approach. Once they had gained their nursing qualification/s they slowed down their PPD activities, only completing those activities required which were in their job description, employers' additional stipulations

for current trainings, and regulatory body specification for re-registration and maintenance on the nursing register.

Starting, moving and keeping going: several women viewed themselves as having to continue to carry out PPD activities whilst they were still in the mind-set of studying (e.g. having qualified recently). They had identified which PPD activities they wanted to do that would meet qualifications/job specification requirements for their current job and enable them to apply in the future for jobs of particular grade/speciality they were interested in.

Moving and slowing down on their PPD journey – what stops women from moving at the pace that they would like to be moving at? Several women were moving on their PPD but having to slow down. Listed below are some of the categories previously cited in the preceding themes, which are provided as examples to recall what caused women to slow down their pace.

Embracing PPD, rejected by Service Needs: Several women had to pay for one module/course at a time: For others, they had no other way to fund courses and therefore had to stop. Several never started on their PPD journey because of the lack of support from their employers. Other women continued to study, self-funding their PPD activities when they could.

> *"I don't think there's as much support for that as they make it out to be … A few of my colleagues had applied for courses and they hadn't been given them and that was the reason why, because it couldn't provide a benefit to the ward or the organisation".* Karen 35 UK

Unpredictable funding: Several women had received small chunks of funding over different periods of the year, and it was often unpredictable as to whether they would definitely receive the funding. For some, this inconsistency led to a complete halt of PPD actively (and risk of failure to complete their programmes of study). For others (often women who had taken the planned career approach), this led to more creative approaches to reach a solution to gain and manage funding.

Supporting nurses in different ways, and not supporting nurses: Some line managers offered and gave support, but even with some of these line managers the nurses experienced that other rules were sometimes put in place, obstructing the development of the individual. Some of these rules were written down, but many were "hidden", only to appear when support was asked for, and often verbally expressed with no policy or procedures to back them up. The majority of the women from **SA and the UK** said they did not gain support from managers.

Access to time for PPD activities: Women spoke of having no one to cover their absence from the work place, giving reasons such as a lack of staffing and adequate skill mix, which prevented access to time for PPD activities during paid and unpaid working hours. Several could not be released from the workplace to attend PPD activities that required "face to face" and/or taught engagement.

Fragmented time: The majority of women could rarely access large chunks of un-interrupted study time due to work and family commitments. This resulted in moving pace and slowing down.

Delay in moving pace or starting on their PPD journey: This category gives some insight as to why women delayed moving and engaging in PPD activities or starting on PPD activities in the first place. Some women wished to engage in PPD activities. Many of these categories related to the individuals and their current circumstances, which could be a combination of personal, work and home circumstances. These circumstances delayed women from moving forward or starting on their PPD journeys. For example, Amy 28 UK had been offered a place to study on a course at short notice. She had turned this down because she had not planned it with her family. Natalie 36 UK refused to do any further study because of the effect it could have on her family.

Planning: Women placed high importance on the organisation, planning and agreements they felt needed to be made with other members of their family at home before engaging in PPD activities. Time, finances and resources needed to be taken into account, so they could be successful in their PPD activities. Many women would delay moving on their PPD journey, and only contemplate undertaking PPD activities when they had everything planned. Because of this, women were least likely to take up an offer to carry out PPD activities at short notice. Suggesting that women's refusal to engage in PPD activities at short notice was remembered by managers. And this was taken into consideration when managers considered who they would offer opportunities for PPD activities in the future.

> *"I brought my children up first I didn't want to leave them. I didn't want my head buried in books, when I should have been reading to them. So when my youngest was fourteen I started on a diploma".* Amy 28 UK

> *"It took a lot for me to actually get into that mind set of okay, I have to become a student again and it took me sitting with my husband, sitting with my family, telling them that it's going to be sacrifice, it's a life changing, because my son was, 11. So now for the mother to not be there the whole time anymore, it took a lot. It took a lot of adjustment."* Zika 41 SA

When the "time was right", and when the "time was wrong" to carry out PPD activities: Several women described it as personally the "wrong time" to carry out PPD activities, and so they did not commence activities until the "time was right" for them. "Having a go" meant they would only undertake activities over a short period of time, and then stop.

Some women's lack of confidence in their own abilities (for example viewing themselves as "not academic") resulted in them resisting starting or moving on in their PPD journeys. For some they would only commit to undertake PPD activities over a short period of time because they viewed this as a less risky move to make. Women in the UK could opt to study a module rather

than a whole course, and as previously mentioned April 3 UK was a classic example of this.

Delayed and infrequent funding: For several women, fragmented funding delayed and slowed them down resulting in a longer period taken to complete a course. Many women who were not successful in gaining funding and then did not self-fund to maintain the continuum of studying, stopped on their journey. Several planned to stop only for short periods of time. Several faced the risk of not completing their study programmes because they were unable to complete qualifications because the time allowed had expired.

No funding: Some women could not start on their PPD journeys as they had no spare money to pay for PPD activities.

Stopping on their journey– women perceived to be "standing still": It was found that some women had planned when to stop and also when to start up again. Others had not planned to stop, but then needed to for their own reasons. Examples to why they stopped: moving home to live in a new geographical area, moving to a new job and/or different employers. Women perceived that once these things had improved, then they would be able to continue with their PPD activities. Some women had stopped for a longer time than they had originally intended. Others members of the nursing team (including managers) could have perceived these individuals to be "standing still" with no plans for further PPD activity. However, the findings indicated that many women set their minds on what they wanted to do, and when they planned to start moving on their activities again.

Embracing PPD, rejected by Service Needs: Some women had to pay for just one module/course at a time. Others perceived they had no other way to fund courses, so when they did not receive funding support from their employer they had to stop their PPD activities (often academic courses that required financial payment).

"Work-Life Balance": When engaging in PPD activities four women found that the work-life balance shifted and was no longer being achieved. Women in this position were aware of potential failure if they did not achieve this balance. Because of this threat of failure, women delayed or stopped their PPD activities. Others adopted strategies to help them continue their PPD activities.

"Wrong time" so having to stop: A few women had started activities and then felt they needed to stop, as circumstances were wrong for them to carry on, because priorities and other pressures (personally, at work and/or at home) affected their activities. Examples of these include what women constituted as being the wrong time. Some women said they could not change their current circumstances at home and/or at work. Family life took priority along with work, and they were not able to "add anything else into busy life". For several women it was not the right time for them mentally to take on a new challenge. For others there was no time, no spare money, and no support for childcare. They had children attending school and rotated work around school hours.

> *"I think you know if you make up your mind to do something, there's a lot of sacrifice that goes with that and you just have to do it. It doesn't change if you moan, or if you groan and there's no money can't afford to waste it".* Mandisa 23 SA

Once qualified, "moving as fast as they can" until they perceived that they may have to stop or slow down: Women were either in their early adulthood, having been qualified for 0-4 years or had qualified later on in life such as June 4 UK. Both groups described themselves as having planned their careers.

The **younger women from both countries** had taken the view that they would engage at a high level of PPD activity until they got married and had children, whilst they "had the time". They envisaged that if they gained the qualifications "now" then this would give them access to jobs of a higher

grade later on, whilst they were gaining experience. In comparison to **UK women**, **SA** women who wanted to go into management posts had different experiences. For they "had to wait" until they had gained up to 10-15 years of experience before they were able to apply for these posts. Women from **both SA and the UK** perceived that by doing further studies, many years later they could be at an advantage in that they could continue to provide for their future families and have the choice to work part time in a job employed on a much higher grade. Others thought they would not be able to engage in PPD activities outside of working hours once they had families to care for.

> *"I always felt that I put myself under a lot of pressure to keep moving, because I wanted to keep moving and then get to a point where I can stop in the future and go part time".*

Karen 35 UKSome older women from **both countries** (three who had qualified later in life) perceived they should do as much PPD while they had the opportunity to do so, (as previously different circumstances had prevented them from doing so) and that it would support future applications for higher graded jobs. On retirement, they would get a better pension having worked in a higher graded job such as June 4 UK.

Moving Fast: In addition to the category above, there were other reasons as to why women were moving fast in their PPD journeys. For many it was that they had the time and space to focus on their PPD, for others they realised that they would need to gain qualifications to stay in their current jobs and/or to apply for other jobs. As previously mentioned, these included White **SA** women who saw the SA BBE[24] (2013) legislation posing a threat to their job security. These women had come from having used either planned or unplanned career approaches.

Slowing down on their journey having carried out a great deal of PPD: These women acknowledged that they had achieved their PPD aspirations. Because of this achievement these women were found to be slowing down to stop – several acknowledging that previously their work-life balance had not

been very stable, due to PPD activities. They did not want to commit to any further PPD, that might impact badly on their friends and/or families having finally achieved a work life balance. Natalie 36 UK was an example of this.

5.3.2 Women controlling and managing their PPD journeys – 2nd sub-theme

It was found from analysis of the above themes that many women "controlled their careers and PPD journey", from when they planned to stop and to when they would start moving again. Women were found to move at different paces according to their current circumstances and their current stage of life. Women's different perceptions of PPD activity was also taken into consideration when managing their PPD journeys. The findings highlight that just because a woman is "standing still", it does not mean that she has no interest or desire to engage in PPD activities. It maybe that her non-activity was down to: her own perception about the levels of PPD engagement required; her perceptions and/or experiences of her employer's lack of support for PPD activities; her pace was limited by her circumstances; or they were sometimes given more importance because of life events that affected women. Several women engaged in a basic level of PPD activity for a number of years until their circumstances changed. Several women, during this time of low-level engagement, had planned what PPD activities they were going to engage in once they had more time and space to undertake these activities.

Charlotte 9 SA felt that as a result of not receiving any development opportunities *"I just stood there once and told myself - I'm going nowhere".* The action she took was a major risk financially by taking *"a major salary cut back from where I was to here".* By changing jobs she was able access better development opportunities with her new employer, developing herself was very important to her.

There was a distinct difference between the pace of nurses who had a planned career approach and those who had an unplanned career approach. Women who had career aspirations moved and changed their pace a great deal more than those who had no aspirations. However, some only developed aspirations later on in their working lives.

Several women who had achieved their planned goals were willing to change their pace, and to slow down once these had been reached.

"When I finished the degree, I vouched I was never going to study ever again because it was hard". Anna 27 UK

"I do have a lot of plans in my head … a future career path". Laura 16 SA

However there was also recognition that women who did not plan their careers had managed to have very successful nursing careers. For several women they were at the "right time and the right place" and had a line manager and/or employer who supported them. They were able to take advantage of their employer's initiatives for example to fund Masters in Advanced Practice courses, mentorship modules, nursing administration courses and courses that would support the specialist nurse grade. Several women had put plans on hold, giving their families and homes a higher priority than their nursing careers. However when the circumstances changed, they were often ready with their old or new plans to engage in a higher level of PPD activity.

One line manager argued that sometimes women's approach towards PPD changed. As a matter of course during appraisals with her staff she always took the opportunity to engage more of them in PPD activities, leaving it up to the individuals to take up or decline the offer. This helped her to identify if these RNs wished to undertake further PPD activity.

"As a manager … I've always mentioned PPD activities … to see if they are interested". Jane 29 UK

Many women explored opportunities for development and decided when and how they wished to undertake any PPD activities, regardless of whether they had planned their career or other members of the work team had identified them as "high flyers" who would progress quickly up the career ladder.

5.3.3 Planned and unplanned career approach – 3rd sub-theme

The definitions derived from this research on women's perceptions and experiences as to what an unplanned career approach was, and what a planned career approach is, have been defined below.

Unplanned career approach: This approach was perceived to be when someone having gained their nursing registration/qualification only planned to undertake basic PPD activities that involved mandatory/in-service training and any other training stipulated by their employer. Their line managers influenced other PPD activities as well as being individually chosen to increase their knowledge and skills required in their current jobs. WRNs engaged in further PPD, the purpose being to remain employable in the future.

"They always said that I had more potential … why don't you move on?" Charlotte 9 SA

> *"I really didn't have a clear picture of how that was going to impact on my life at a later stage. This one thing as I progressed, I realised, it was a good move that I did that and that ... It was not that much clear in my mind at the time".*

Rachel 20 SAThe planned career approach: This was perceived by women to be when someone has indeed planned their career. Most commonly they will have planned their career before, during or not long after gaining their nursing registration/qualification. Several women set themselves career pathways they wished to follow, others had fewer options as to which direction their careers could follow, but set them none the less. This planned

career approach was common with young women, and women who had qualified in later life, within the 0-4 years post registration experience. Women in **SA** heading towards their 40s and 50s also had a planned approach as they had worked as RNs for many years. They recognised that if they gained their Masters' qualifications they could then open up their own private clinics, which they could then run for many years.

"I don't want to sit in one place for more than twenty years, at least. I need to move forward… So my aim was to do the masters". Akua SA

"I always knew where I wanted to be so I think, on a personal level, it was very important to me to be able to access courses". Helen 33 UK

> *"I think I've chosen a different path. I've made specific choices … with other nurses, they enter into a job and lot of their personal or professional development happens, because it is institutionalized. You know, like you will sit with your manager and she has been watching you and sees that you are good with cardiac patients. So she's like why don't you go on a cardiac course? Whereas with me, a lot, all my kind of professional development in terms of direction, has been self-initiated".* Angela 12 SA

To summarise: this sub-theme showed that women were found to have plan to undertake PPD activities that they knew would support the career pathway they wished to follow. There were women who had taken an unplanned career approach, yet they were still successful in their careers. For they had continued to undertake PPD activities which aid their development and gave them direction in their careers.

Main Theme 4 on Women's PPD Journeys highlights that women's PPD activity moves at different paces, and often this pace continues to change throughout their working careers. For many women from **both countries** who had aspirations and planned careers, these plans did not always go as originally intended. Several of these women felt that the traditional relationship between themselves and their employer had changed, arguing that this was because employers were only interested in the service provision

and were not supportive of the individual RNs' needs which was to develop themselves and their careers.

Many women were found to control and manage their PPD activities and PPD journey. Several had chosen when they would stop and start again. Others moved at a fast pace until they chose to slow down. The findings show the difficulties women faced, and that some had no choice but to stop. However, many women had control over their PPD journeys, for example choosing to give responsibilities at home a higher priority than PPD activities at a certain stage of their lives was a typical example of this control. For several women their PPD journey was less eventful in comparison to others. On gaining their RN qualification they chose to only engage in PPD activities at the minimal level of PPD activities and only within paid working hours. This also demonstrates that many women had resisted barriers and found ways to overcome the difficulties and/or oppression that they experienced.

5.3.4 Conclusion of the findings

One core theme and three main themes were identified using CGT:

Women's perceptions, experiences and rewards of personal and professional development.

Women's perceptions and experiences of engagement, aspirations and circumstances that can influence and/or limit PPD activities.

The hidden costs of PPD activities and the strategies and techniques that women used to overcome the difficulties.

Women's PPD journeys.

Each theme was found to be inter-connected, detailing the variety of women's perceptions and experiences, the barriers, constraints and life events that affected their approach to undertaking PPD activities, and their perceptions and experiences of the benefits and rewards of PPD. It often

took only one or more changes within any of the themes for it to impact on women's level of engagement in and potential enhancement of their PPD activity.

These unique findings have shown the complexity of PPD from micro to macro (Charmaz, 2008), and the emerging themes constructed from my analysis have brought about new knowledge on this topic. While recognising there are some differences between SA and UK healthcare employers' approach towards PPD and RNs roles which has impacted upon WRNs perceptions and experiences, it was also found there were many similarities. Some women for example only perceived PPD to consist of engaging in PPD activities at the basic level within paid working hours that fulfilled their job contract and stipulated by their employer and their nursing registration body (SANC/NMC). They viewed PPD as only being only carried out in paid working hours. Other women held the perception that PPD is something that they wished to engage in and chose a level they wished to engage in. For many WRNs from both countries it was very common to find this involved undertaking PPD activity outside of paid working hours. Some women had aspirations which could be achieved through their engagement in PPD activity, hence it was serving a worthwhile purpose. Aspirations could be personal, professional or both. Some women were not able to engage in PPD at the level that they wished, due to their circumstances and/or other personal reasons. Circumstances controlled and limited PPD activity in addition to other reasons, such as being a time in their lives, in which other things took president or a recent life event, meant it was "the wrong time" to carry out activities. Several women had aspirations they wished to achieve. Other women predicted the hidden costs of PPD, whereas others had not been aware of them. Women experienced and perceived barriers that would prevent them from achieving PPD activities. Women used techniques and strategies they found effective in overcoming the difficulties they encountered when undertaking PPD activities.

5.4 Concluding how the findings of this study influenced the design of the PPD Model

The emerging PPD Model makes a unique contribution to knowledge and acts as a basis for further theoretical development. This PPD Model has been constructed by approaching the research through CGT methodology (Ramalho *et al.* (2015). The 1 core and 3 main themes identified in this research are integral to this model. The PPD Model demonstrates the reality of RNs' perceptions and experiences that may affect women's approach towards PPD. Circumstances and the hidden costs of PPD both influence the level of engagement; they can also limit engagement and have an impact on the level of success. For WRNs who have aspirations that are related to PPD, this may also influence engagement in PPD. Women's lives flex and change, along with the circumstances and hidden costs of PPD, all of which have an influence on the pace of women's PPD journeys. Women are found to adopt the use of strategies and techniques to navigate their way through their PPD journeys. Women held perceptions of what the rewards and benefits could be for PPD and also experienced, having undertaken PPD activities, some that they had not envisaged.

The findings of this research questions the conventional definitions of PPD and reconceptualises it as a dynamic interplay of components represented by the 1 Core and 3 Main Themes. Women WRNs who worked for an employer, held two differing **Perceptions of PPD**. These components formed the basis of the PPD Model (Figure 6) shown below, for perceptions of PPD had an impact to how women approached PPD. Perceptions were found to come from two opposite aspects. One of these perceptions was based on the **WRNs perceptions of the differing levels of engagement** in PPD from minimum to maximum levels of engagement (Figure 4, Chapter 5:, 5.1.2), of which most but not all WRNs change from one level to another continuously throughout their careers. The other perception was **WRNs Perceptions of their employer's approach** and vision of PPD for RNs, this

was perceptions of employer-led PPD (Figure 5 Chapter 5:, 5.1.1.) which WRNs viewed employers would support or not support WRNs' PPD. Next the **Circumstances** and **Hidden Costs of PPD** (Figure 6, PPD Model) could have an impact on engagement in PPD. These components did not stay fixed, rather they were fluid with the ability to change their weighting and effect on WRNs PPD. **Strategies and Techniques** were used to aid the success of PPD. **Rewards and Benefits** perceived and experienced having undertaken PPD, could also influence engagement. **Aspirations** could develop or decrease at any stage of WRNs' nursing career. All these components could impact on the speed and pace throughout women's **PPD Journeys.**

At present, there are no PPD Models that could be used universally to demonstrate the reality of WRN's PPD journeys. There are now nursing career frameworks published by both the UK and SA (NHS Wales, 2010; NHS Education for Scotland, 2018; SANC, 2018). They are argued to be a visual tool, which can be used to plan nursing careers and identify development of knowledge and skills that will enhance them in the role as an RN, where the individual can identify their own development needs and line managers can identify development needs of their staff members (NHS Scotland, 2018). These frameworks play an important role by firstly acknowledging that the old career pattern of RNs rising from junior to Sister/line manager of the ward/work area has changed, offering some transparency and raising awareness of what knowledge and skills are needed to progress into a variety of roles.

However, these frameworks make statements that question if these are based on the realities of RNs' working lives. For example, the Scottish NHS framework (NHS Scotland 2018) claims the manager will inform RNs of development opportunities – but the reality is there may be no opportunities, and if there are, they are most likely to be limited. It indicates that the RN's manager will offer a supportive discussion. However, from the findings of my

study, the reality is that the manager may or may not be willing to offer any supportive discussion. The framework suggests, the manager may help identify individuals' development needs. However, my research findings tell us that it is an exception, rather than the norm for RNs to experience having a manager who is proactive in planning and identifying development needs. The frameworks may demonstrate a plan of jobs that can lead to career development, but they do not offer a realistic way to design a realistic plan for RNs' personal and professional development. The portfolio could be used to plan women's PPD, but this is all dependent on the knowledge that women have on how to use the portfolio effectively.

The findings in my study offer a unique contribution to knowledge for it offers a new definition of PPD. PPD is the need to grow and to continue to develop and learn. For RNs, PPD is about having self-awareness; keeping their knowledge and skills up to date within the speciality they work in, and with the latest policies and procedures of the organisations they work for. The PPD model demonstrates that it is multidimensional, components interrelate with one another can be used as both a tool for RNs to use but also to inform PPD education, policy and research. The Model enables emerging theory for WRNs and may help guide future research in this area. The emerging PPD Model (Figure 6 below) aims to raise awareness of the realities that surround WRNs' PPD by highlighting key components (identified in the Themes), it explains and analyses the complexity of the dynamics and inter-relationships they have with one another. By indicating these key components, the Model can be used as a tool to educate and help guide RNs (this includes managers, as an activity for RNs to undertake by themselves or with others) through their PPD journeys by getting them to consider and question how things in their personal and professional lives may influence or limit engagement in PPD (this includes circumstances and the costs of PPD); and to consider to how any actions could be taken to reduce the barriers, and any strategies or techniques that could be used to help WRNs navigate through

their PPD journey. Any aspirations, rewards or benefits that they wish to achieve can also be considered in their planning. The PPD Model could be one of the standard tools situated within RN's portfolios.

The PPD Model could also be used by RNs as a tool for those who are currently undertaking PPD but experiencing difficulties. The PPD Model could encourage the RN to identify what the difficulties are and consider strategies or techniques that they could use to overcome these. This could also include recognising that if nothing can be implemented to improve the current system, they could make the choice to reduce their level of engagement in PPD activities with the plan to return to these activities at a later date when "the time is right" for them.This PPD Model identifies that there are two perceptions of PPD: what WRNs perceive employers' view of PPD to be, and what WRN's perceptions are of PPD. It is those perceptions that can influence the direction and pace of women's PPD journeys and the different levels of engagement from minimal to higher levels. This Model allows RNs (and others, including line managers) to identify their current level of engagement. On having considered their development needs and wants, they may wish to change their level of engagement to achieve their PPD objectives, preventing perceived failure, planning what they feel needs to be in place to make the time right for them to engage in PPD.

Most importantly, this PPD Model may also act as a way of empowering women by encouraging them to assess and evaluate their current and future situations. Self-knowledge can give WRNs the power and control to navigate through PPD journeys. This Model may help women establish, reflect and increase their own self-knowledge as to why they have had difficulties in engaging in their PPD activities, and encourage them to review what action they would need or could take. This Model could also be used to educate and increase managers' awareness of the complexities of WRN's lives and how this may affect and influence their perceptions and decisions on PPD. As found in my study, PPD activities rarely stay within the professional arena.

WRNs' development overspills into women's private lives. Employees may not wish to disclose information, for example on their home circumstances, but they could state if their current circumstances inhibit development activities outside of paid working hours. This brings me to conclude that this Model provides an emerging theory of PPD as a basis for further theoretical development. Acting as a tool alongside career frameworks to support RNs' PPD.

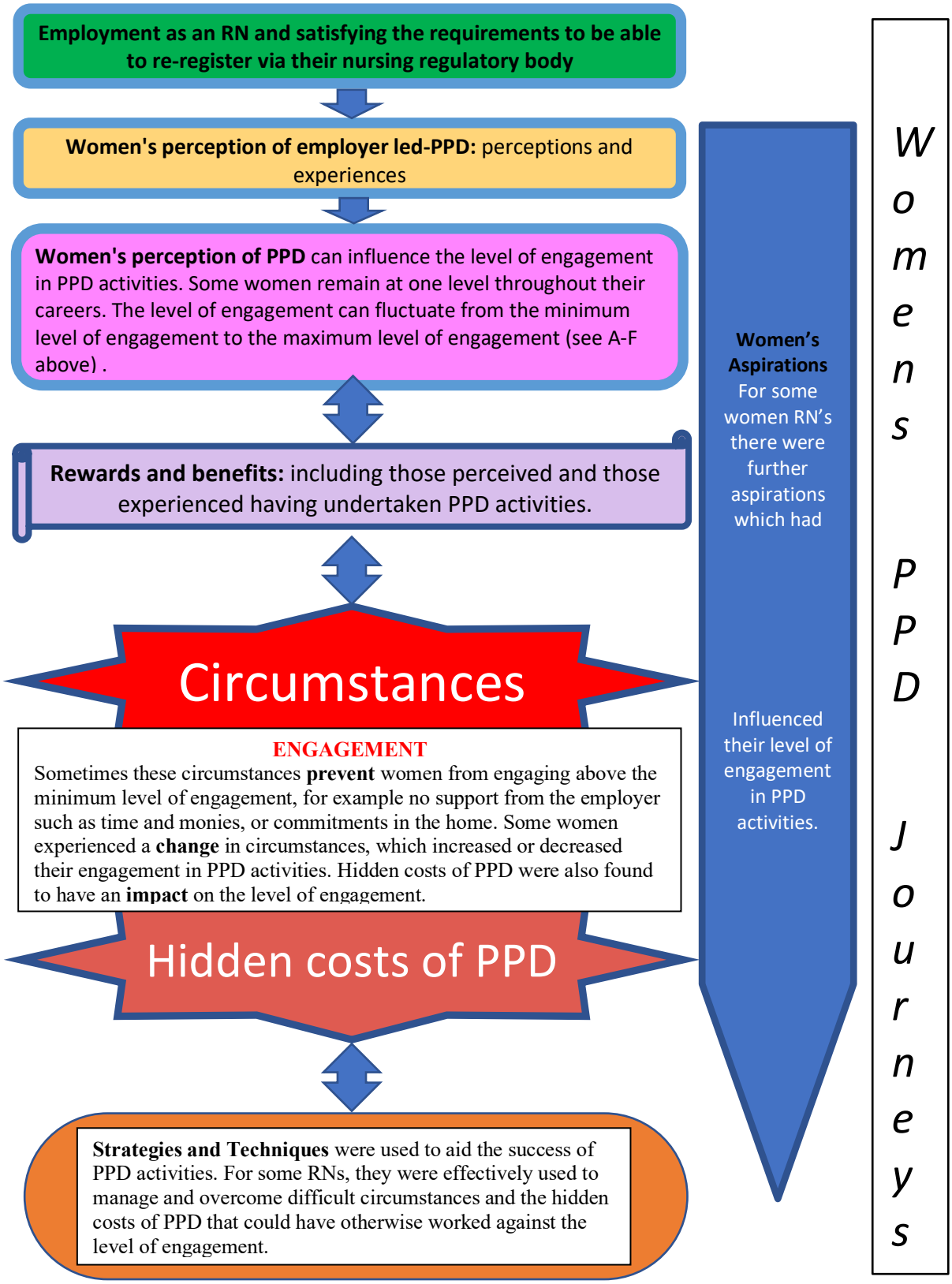

Figure 6 The emerging PPD Model

Chapter 6: **Discussion**

6.1 Introduction

This discussion chapter leads on from the findings presented in Chapters 4 and 5 to answer the research questions about WRNs' PPD perceptions and experiences in the UK and SA. The findings showed the key components influencing WRN's approach towards PPD which were: Core Main Theme 1: Women's perceptions, experiences, benefits and rewards; Main Theme 2: Women's perceptions and experiences of engagement, aspirations and circumstances that can influence and/or limit PPD; Main Theme 3: The hidden costs of PPD activities and the strategies and techniques that women used to overcome the difficulties; Main Theme 4: Women's PPD journeys. The dynamics and inter-relationships between these components showed a pattern of complexity that led to supporting the proposition that women's PPD journeys fluctuate and that these components give the answers as to why this is so.

The chapter then discusses in depth the research findings; Core Main Theme 1, and Main Themes 2, 3 and 4 as incorporated into the emerging PPD Model. The PPD Model is presented in Figure 6 as an emerging theory and tool women could use to help empower themselves and others. I discuss the significance of my findings in relation to the existing body of knowledge on WRNs' PPD.

This study was initiated having read research studies that raised awareness of RNs' perceptions and experiences of PPD (Gould *et al.* 2007; Stafford and Banning. 2008; Schweitzer and Krassa, 2010). These studies indicated that RNs were facing difficulties when engaging in PPD; however, the findings provided a limited insight into the difficulties that WRNs were facing and the reasons why these were being encountered. These research findings led me iteratively to develop the new research knowledge generated from this study. It had been recognised that it was important to explore this further, as RNs

today need to undertake PPD to remain up to date and safe within their practice. RNs are now expected to record their PPD activities to present as evidence to support re-registration on the nursing register. It needs to be noted the study aimed to find out women's perceptions of PPD. This also included what they thought men's perceptions were. It did not aim to collect data on men's perceptions and experiences. Since this study commenced the requirements of evidence have changed for both UK and SA nursing regulatory bodies. Without engagement in PPD, RNs could find themselves unable to re-register, and at risk of losing their professional status, their jobs and income.

On commencing this study, it was aimed to collect data on women's personal and intimate experiences and perceptions. For it is these Hughes (2002, p154) argues are situated with the knower, who has an understanding behind the meaning and hence *'knowledge emerges as a never-ending process'*. Wrongly so, it had been understood that experience was based on participation, and perception was observation of the event or person. It was quickly learnt however, that experience can also be gained through observation. Perception is having an understanding or having an awareness about something, and it can be formed as a result of the individual's observation or something they have perceived. When placed together, perceptions and experiences can result in creating a basis of knowledge and understanding that these interactions between perceptions and experience, have been ignored in previous studies on RNs perceptions which brings me to suggest that this may have occurred due the study designs being of a quantitative nature (Richards and Potgieter, 2010). Hence in my study it became evident that knowledge can be gained from knowing something that may have been gained through experience or perception by making an association with how this links to the relationships that, in addition, incorporate the values and meanings that women may hold (Ramazanoglu and Holland, 2002).

What was not considered prior to the study was that a woman's experiences may not have originally stemmed from her direct experience; they can also be formed from her indirect experience. Women observe, they talk to each other, listen and support each other, and this too creates their own lived experience, and the knowledge gained of this experience may also shape their perceptions. Thus, one woman's experience can also become another woman's experience. In the findings of this study (Theme 1.7.2.) there appeared to be shared knowledge between women on their employer's "attitude" or "approach" towards PPD that led to other women, for example, to "not to bother to ask for support" because "they already knew what the answer would be". Because of this, their experience became a perception that was based on the knowledge of what they knew.

6.2 Core Theme 1 - Women's perceptions, experiences, benefits and the rewards of personal and professional development

The literature review (Chapter 2:) revealed sources that focused mainly on professional development, with very little on personal development. Jasper *et al* (2006, p33) book claimed professional development:

> *'need not be difficult or complicated. Nor does it have to be driven through a model or framework that requires you to understand the concepts involved before you can use it'*. (Jasper *et al*., 2006, p38).

Furthermore Jasper states that use of simple tools such as REACT (Relevant, easily definable, achievable, cost- effective and timely) and 5WH (what, why, when, where, who and how) are; *'simple strategy for directing professional development activity'* (Jasper *et al*., 2006, p38).

Jasper *et al.* (2006) demonstrate an awareness that RNs need to plan, prioritise and decide to what activities that they wish or need to do (Jasper *et al*. 2006) (as so do the ICN (2010) in their career guidance). Jasper *et al*

(2006) argue that this *'will involve different levels of commitment, time and resources'* that extend to relationships, responsibilities and interests outside of the home. However what they failed to do was elaborate further, or acknowledge the complexities of PPD. What we already know from the literature review is that there is evidence of what nurses think PPD is, some of the reasons to why PPD is important, why RNs wish to engage in PPD, and some of the difficulties that RNs face when undertaking PPD. However, this is a fragmented picture as there has been a lack of depth in the issues raised, and the dynamics between them have not been explored. For example professional jealousy and womens' use of silence added unique understanding to the processes involved in women's PPD. What this research did was explore these areas of the personal and professonal in a greater depth, and the dynamics between them.

Theme 1 - womens perceptions, experiences, benefits and the rewards was the first theme identified. Perceptions and experiences play a very important part in WRNs knowledge that they gain, being applied to the challenges they face when planning and undertaking PPD. This study has generated new knowledge on the phenomenon of WRNs perceptions and experiences of PPD. The emerging PPD Model (Figure 6) has drawn upon this new knowledge to demonstrate a purposeful representation of the dynamics and inter-related relationships. This model gives the potential to develop an alternative theory of PPD, which proposes that by having this knowledge WRNs will be able to empower themselves and others around them. Galie (2014, p290) argues that for women to be empowered they need consider to what life choices they have, and *'relate to the ability to make strategic decisions and to act to implement them'.* That agency is when women have identified their goals, and how to act upon them, taking into account to what they conceive as possible.

> Arguing that *'constraints to the capacity of exercising agency include the lack of alternative choices and the lack of opportunities to materialize these choices' that*

> *'critical consciousness is needed that questions the social order and conceives the alternatives.'* Galie (2014, p290).

This preliminary model could be used as a vehicle to assist women in understanding the differing perceptions of PPD and the experiences that may have had an influence on their past, present and future PPD and aid them in planning and managing their PPD. The construction of the emerging PPD Model started to take place when analysis of the data brought me to recognise that WRNs held two differing perceptions of PPD and how this impacted on their PPD. The analytical process of building the preliminary model resulted in discovering circumstances and the hidden costs of PPD were separate entities, rather than grouped together as suggested in previous literature (Banning and Stafford, 2008; Hughes, 2005; Beatty, 2001).

6.2.1 Comparison between two countries

The comparison between the two countries was essential to the study design, for PPD is required worldwide for all RNs (Ember and Ember, 2009). Brekelmans *et al* (2015) confirmed this; as they reflected on their study and its limitations, stating that it had only provided findings on what nurses in the Netherlands perceived as factors influencing development activities. They argued *"further research is essential for distinguishing the views of nurses in other contexts and countries"* (2015, p18). Constant comparison through CGT provided more opportunity to take an overview of why WRNs perceptions and experiences of PPD had been shaped by their contexts and countries and presented in this way (Pilcher and Whelehan, 2017).

6.2.2 Definition of PPD

The literature review established that there is no universal definition of what PPD is for WRNs. The conclusion was that without a universal definition the understanding of what PPD is, and what it is not, had rendered the term ambiguous and open to a number of interpretations.

CPD was defined by the Department of Health (DOH, 1999) as a group of activities that supported the concept of LLL within healthcare. This broad definition was questioned (Chapter 2:), findings of this research suggest that WRNs interpreted the term CPD – as associated with activities carried out inside paid working hours. That employers placed priority on professional development activities that they class as mandatory core training and additional activities aligned to service needs. With less focus or support for other developmental activities that aid LLL. The findings argued that CPD is no longer applicable because WRNs' PPD is increasingly conducted outside their paid working hours. The professional has become more personal, which has resonances with the feminist theory that argues that the personal is political for WRNs (Pilcher and Whelehan, 2017). Employers' lack of support for PPD has led to WRNS using their personal private time and space so that they can continue to develop themselves.

A definition of PPD has been produced representative of the WRNs whom participated in this study, which Philippou (2014) impressed was needed. This definition adds a unique contribution to knowledge. PPD is the need to grow and to continue to develop and learn. For RNs, PPD is about having self-awareness; keeping their knowledge and skills up to date within the speciality they work in, and with the latest policies and procedures of the organisations they work for. This definition sets out clearly what PPD is for RNs registered to practise.

6.2.3 Accessing and engaging in PPD activities

The literature review established what PPD activities could consist of and recognised these were divided into formal and informal PPD activities (Ely and Burton, 2011). There were very few examples given by women in this study on how their line managers were proactively providing opportunities for informal PPD activities. This was surprising because there is a wide range of informal PPD activities that can be undertaken within the workplace during paid work time, Pool *et al.* (2016, p24).

The majority of women from both countries perceived informal PPD to be core training and formal PPD as specialist /academic courses. This suggests other types of informal PPD activities, are not in use within the workplace. I concluded that RNs were being guided to undertake PPD activities they could access within the constraints of the working environment, excluding the depth and breadth of PPD activities that could be offered if the environment had enough resources (Stafford and Banning, 2008; Ely and Burton, 2011).

This may also explain why research on formal education continues to focus on specific areas, instead of focusing on PPD as a whole (Kinsella, Fry and Zecchin, 2018; Price and Reichert, 2017; Richards and Potgieter, 2010). This is a worrying finding, as it was perceived it was the line manager's role to guide and influence RNs on how they could develop, and to facilitate and organise opportunities for them to engage in PPD activities (NHS, 2015). Yet, it the findings indicated it was the managers (excluding those exceptional cases) who were no longer suggesting that these informal PPD activities be used.

The common answer to why RNs were prevented from undertaking PPD activities was due to "short staffing" this was confirmed by other studies (RNC, 2020; Price and Reichert, 2017; Richards and Potgieter, 2010). It could be argued that 'short staffing' is a broad term used to describe many things happening within the workplace, e.g. not enough staff in the team to run the service and care for the number of patients on the ward, poor organisation of skill mix affecting the staff rota with no staff spare that would enable the release of RNs from the workplace to undertake PPD activities outside of the work area, and not enough staff employed in a certain grades that have the specialist knowledge needed to manage the workload, nurse retention issues and nursing vacancies that have not be filled, staff sickness resulting in those left in the team having to work longer and much busier shifts. These findings are echoed in the RCN (2020) report on Gender and Nursing as a Profession.

The majority of UK women and SA women working in rural areas, who participated in this study, struggled to undertake core training PPD activities within paid working hours. This situation had been reported by the UK's RCN (2013; 2015). SA nurses' trade union DENOSA has since reported that the problem of short staffing has increased, which in turn has resulted in fewer women being able to engage in core training, regardless of the location that they work in (DENOSA, 2016).

An urgent revision of staffing policy to accommodate RNs PPD is paramount. For without access to and/or engagement with informal PPD activities, this reduces RNs' opportunities to develop within their roles as RNs, which professionals need and must have the right to do so (Jasper, 2006; Kangasniemari *et al* (2010).

Several line managers were making further decisions as to which PPD activities RNs could access. Core training, had traditionally been regarded as CPD because it was delivered and paid for by the employer and conducted within paid work time, and aligned with service provision. Some core training other than the basic mandatory training that all staff have to do, involves another level of training, such as clinical skills training. It was shocking to discover that several managers did not allow women time to engage in these activities even though they were being delivered as CPD that would quite clearly aid their knowledge and skills in that would benefit patient care. For example **SA** WRNs working in rural areas had little or no access. Some WRNs denied access had taken personal action to benefit patient care, hence Munroe's (2008) argument of 'the charity paradigm' discussed in the literature review is evident here.

These findings demonstrated the extent to which employers are no longer willing or able to support RNs to engage in core CPD training within paid working hours. Such actions dis-advantage many women from PPD, excluding those who could not, or would not sacrifice and donate their

personal time outside of paid working hours to enhance their clinical skills that would benefit the service provision, rendering CPD as being marginalised by employers and not supporting RNs PPD (Munroe, 2008).

These findings challenged the notion of informal PPD activities that could *"*easily be undertaken during the RNs' paid working hours*"* (Chipchase *et al*, 2012). This study highlighted that difficulties in engaging in PPD activities were no longer just about women not being able to get support for formal courses, but also informal PPD activities. Employers and managers have limited the range of PPD activities within the workplace and these actions have subsequently changed the way that women perceived and experienced PPD having a negative impact on their development.

SA WRNs expressed frustration in not being able to have the right to engage in these and were aware that this may impact their practice and the environment that they worked in, of which Kangasniemari *et al* (2010) argued were RNs professional rights.

RNs are the largest profession in the NHS. In comparison to doctors, they appear to be losing out on accessing employer support for PPD. The British Medical Association (2018) recommend to employers that doctors have 30 days paid leave, including paid expenses every 3 years (employers' mandatory training days are not included in this estimation). There are no recommendations from nursing regulatory bodies that advise RNs to have anywhere near this amount of paid leave. The RCN nursing union (2012, 2017e) attempt to record when RNs are unable to access mandatory/in-service training days, but apart from these, UK employers have no other days allocated for PPD. The SA NHS states RNs are entitled to 3 CPD days per year, which is a step in the right direction, although the process of applying for access to use them is not (Public Service and Administration Department, 2009).

Hence, by employers not providing enough resources for WRNs to engage in core training, this in turn affected the perception and views that they had of their employers. Hence, women's attitude and perceptions towards employers had changed as they saw a division between "them and us" which appeared in the main core Theme 1, as they became aware of the effect of not being given the opportunity to be updated on current practice and issues in healthcare.

Women viewed what Kangasniemari *et al* (2010) argued are RNs rights which influence quality, safety and effectiveness of care and professional ethics. Findings of this study were that no women spoke of only wishing to undertake the minimal level of engagement.

Quality and delivery of core training was found to be varied and had an impact on women's perceptions and experiences of PPD. There was a stark distinction in how RNs in the **UK** perceived and experienced this in comparison to their counterparts in **SA**. All bar 1 **SA** woman out of 24 women spoke positively about engaging in their employers' in-service days. These days were all classroom-based. Managers were responsible for allocating days when RNs could leave the workplace to attend these trainings and transport was also arranged. **UK** WRNs clearly disliked the online training that was the norm for the majority for core training.

UK WRNs often ended up engaging in these trainings during unpaid time, and then they did or did not claim their time back at the later stage as "time-owing" (not overtime pay). The **UK** employers' strategy to use online training created a negative experience of core training for many UK WRNs supporting Munroe's (2008) argument of RNs being pushed into a 'charity paradigm'. The consequences directly affected women's lives by encroaching on their personal time.

6.2.4 Women's perception of employer led PPD

Women's perception of employer led PPD offers a unique contribution toward knowledge on this topic, and revealed a pressing need to examine the effect this perception had on RNs' PPD. WRNs' perceptions of employer-led PPD, viewed their employers as having a set view of PPD that differed from their own perceptions of PPD. This supported Gould *et al*.'s (2007) findings, that women perceived employer led-PPD as being managed by employers via line management, i.e. it was the manager's role (not theirs) to identify and instruct staff to engage in mandatory core training.

6.2.5 Appraisals, managers and PPD

WRNs viewed the line manager's role as conducting the yearly appraisal system to measure and give feedback on RNs' performance. The manager may establish further training and development opportunities that would support the service provision. Literature on appraisals are presented in a positive light with HR policies that support the use and implementation in the workplace. There was no literature on the negative impact of appraisals for RNs and the impact it may have on their PPD. However, this study revealed that less than 10 out of 39 WRNs spoke of having received an appraisal with their manager, which meant that RNs in general were not receiving feedback on performance or guidance on development from their managers. The most common reason given was due to being too busy, with no time. This meant, for many women, they were being deprived of having a discussion around development or planning for development.

Several women gave examples of really positive experiences, whereby managers took their role in developing staff quite seriously and were proactive in their development, such as ensuring all staff had an individual framework for development.

It also came across that those who gave examples of positive support were fully aware that these were exceptional experiences that stood out from the

not so positive experience, describing themselves as 'being lucky' to receive such positive encouragement.

Hence women who received appraisals had their performance reviewed. But what was often missed was discussion on PPD activities that could aid development, and conversations around support were minimal, and often perceived as negative, as managers told them they could offer no support. Brady's (2019) advice on appraisals is the content and format should include a two-way communication process, not a once a year event, but rather a continuous process, that as well as assessing performance should also enable discussion on development.

Some WRNs demonstrated an understanding that when managers said "no" to support for funding or time that this was not necessarily a reflection of the manager, but more so in-directly from the constraints that the organisation placed on RNs' PPD. Whereas others saw their manager's attitude and behaviour as coming from that individual. Who was unwilling or did not have the inclination or/and skills to explore other ways to support them. The relationship between the manager and the WRN impacted WRNs perceptions of the organisational values, of which was found also in Cazier *et al* (2014) study.

Those women who had positive experiences of appraisal said that they had received support for further training and development activities that would also enhance their careers. This included women who had not intended to engage in PPD above the minimum level of engagement and those who had planned to engage at a higher level. These women perceived appraisal as a vehicle to promote conversations on planning development opportunities.

This appeared to alter according to individual experiences.What was clear in this study was WRNs who were undertaking a course that their employers had placed as priority within their business plans gained much more support that those RNs who wished to undertake courses that were not placed as a

priority by their employers such as degrees, Masters (UK) mentorship (UK only), nursing administration (SA only), specialist nursing courses (UK and SA), SA RNs employed on the specialist nursing grade requiring completion of degree or Masters course.

For the majority of WRNs in this study, positive experiences of support was a rarity, decline of financial support was a very common experience. WRNs perceived employers being focused on the service provision. With managers re-instating their position of control and power by warning that there were limits to what support the RN could apply for if, they met the criteria. NHS and private employer websites do not reveal detailed accounts of the monies (including paid work time) allocated for RNs to undertake the various types of PPD activities. Hence it is difficult to establish the amount of support RNs are being given, but what can be established from these findings is WRNs experience this support as not enough.

On the whole, WRNs saw success of gaining support being based on luck. Some argued that in addition to difficulties they had experienced in trying to get support, managers created additional criteria, making the process confusing and more difficult to understand. For some WRNs they had experience of managers obstructing their attempts to engage in PPD. Hence for many WRNs they perceived that they were losing their RNs rights to access PPD. Kangasniemari *et al* (2010) argue that more research and education needs to be carried out so that nurses are aware of what their rights are, report when these are not being met and plan actions to rectify these.

More so for the **SA** WRNs, they were told to, or thought that they had to, wait for their managers to give a date for their yearly appraisal meeting to discuss their development wants and needs. Brady (2019) observed in her own place of work RNs tended to do this, even though regular meetings throughout the year were encouraged, RNs continued to use this approach.

However, it was evident that several WRNs in this study were not sticking to the one appraisal meeting a year approach. Instead they spoke to their managers when they wanted to talk about their development and made it clear that they would never wait for a yearly appraisal meeting, especially as they could not be guaranteed to occur. They were well organised and proactive in planning their PPD activities which is advised as good practice by Jasper *et al* (2006) and the ICN (2010), often planning to engage at a high level of PPD. What set them apart from others, was they did not believe in waiting to ask for support or wait for appraisal deadlines; they were assertive in approaching their managers. Hence they disregarded standard advice given by managers/employers to hold back from planning or undertaking PPD until after attending appraisal meetings, which also meant that they avoided conversations focused around the documentation used for appraisal meetings and instead focused conversations on them and their PPD. It could be suggested that what else made this possible, was the open culture that they worked in and that they had approachable managers who were keen to support them. These women demonstrated agency in their PPD, in that they had the ability to make decisions and act upon them Galie (2014).

Less than 10 women out of 39 said their managers played their part in supporting PPD by offering advice, guidance and support on PPD. What did come from this study was that managers who were knowledgeable supportive role models, were proactive within their own PPD. Those less supportive managers were not viewed to be active within their own PPD and less able to personally reflect upon their knowledge and experience that could benefit their staff and form their knowledge of how to support staff PPD. This left the majority of WRNs to self-navigate their plans and actions for their PPD.

Hence, for some WRNs, their perception was to ask managers for support, but not necessarily for guidance on PPD or on PPD activities that could benefit their development, again adding to the perception of employer-led

PPD being either core training or specialist academic courses. A unique finding was understanding the shift in WRNs' career development plans which had become more of a private and personal affair, rather than it being discussed with the manager as part of their future professional and personal development plan. These findings indicated that the relationship between the manager and the individual RN may have become more fractured and less supportive. To summarise WRNs perceived their rights to undertake PPD, have been reduced, the majority indicating that in their experience managers were not supportive, so they personally needed to take action so they could develop themselves.

What was clear in this study, the majority viewed appraisal as a negative experience, only focused on the service needs, with limited or no support for the individual WRN's requests that would help them develop their careers. Because of this, it may explain why those who had not received a yearly appraisal, were found to act with apathy and did not voice concerns that they had not had an appraisal, for they saw them as no use. WRNs made many suggestions as to why this was so. Findings from Redshaw's (2008) study on RNs' experiences of appraisal showed similar results. He concluded that RNs experience of appraisal was as an *'outdated paper exercise with negative connotations for most staff involved'* (2008, p31). Calling for more appraisal training for managers as they need to invest staff, arguing appraisal '*should now be an integral part of the organisation's culture and not simply a tick-box exercise'* (2008, p31). It is evident from the findings that for employers to have RNs actively engaging in PPD. They need to review the current advice, guidance and appraisal documentation to make PPD more visible and less invisible.

The findings indicated that some WRNs on having expressed the PPD that they wished to undertake felt that their voices were not heard; others felt as an RN requiring development, their managers had silenced their voices by taking away any of the control that they thought they had. This concurs with

feminists Malhotra and Rowe (2013) views in which they assert silence can be used to oppress individuals and groups as a means to gain or hold power. Other perspectives of silence being used in appraisals are discussed in Section 7.4.7. Hence instead of having a positive experience, WRNs experienced the appraisal process being used against them, limiting their opportunities to develop for their requests were not recorded and frequently "the answer was no". This is opposite to employers' claims of appraisals being aimed to develop RNs. Ramazanoglu and Holland (2002) argue issues that dis-empower women must be raised, so knowledge of these issues can be addressed. Pool *et al.'s* (2016) conclusion from their study on motives and development activities was that if employers are aware of what RNs wish to do for their PPD, and the reasons behind this, they can enhance development by providing opportunities for learning and development activities. Brady (2019) suggests that one of the reasons why appraisals are not viewed positively is due to the format and content of the appraisal. That is, if this is altered then it affects the quality of the appraisal. However, this brings me to argue that the only way to achieve this is for both personal and professional development to be prominent in the appraisal. Documentation needs to provide space for WRNs to have the power to document and record if their requests for support have been either met or unmet. HR departments need to take responsibility to publish the results for all employees to see that their voices have been heard and for employers to reconsider how they will re-address the balance of support for RN's PPD.

These findings on managers' approach and attitudes in appraisals commensurate with Redshaw's (2008) study. Redshaw questioned if managers were adequately trained, for the results in his study suggested that they had had no training and lacked knowledge, and in addition some managers lacked the skills and ability to be innovative with staff development. Redshaw argues that standards for appraisal should be set so that managers undertake appraisals that are non-judgemental and non-

biased suggesting that to achieve this, and to aid a change in organisational culture, external training providers could be the solution, for their perspectives would be based from organisations, not just in healthcare, presenting examples of effective ways of working.

Instead of employers supporting the growth and development of staff in healthcare it appeared that many WRNs viewed their managers as using appraisal to assert their power and control. It appeared that this was more so in **SA** for it has a strong hierarchical system based on power and control whereby managers' "unwritten rules" added to criteria that WRNs had to meet before support would be considered. Often, WRNs were only told about these "invisible rules" when they had discovered they had been unsuccessful in getting support, for which there was no literature that brought up this concept[24],leading to anger and disillusion and a lack of trust in managers. This brought me to question if managers viewed the format and content of the appraisal to be based more on performance, management and regulation of staff and employer budgets, rather than development that could aid job satisfaction in which Cazier *et al.* (2014) argues aids the retention of staff. Jasper and Mooney (2013 p12) argue that *'organisations with constraints on budgets are disinvesting and reducing the educational budget, with a concomitant impact'* that they may not be able or willing to fund PPD. This would explain why development is not prominent in appraisal as RNs would like it to be. This may also indicate why application procedures to gain support were dealt with in a way that made it harder (and sound harder), not easier for WRNs to gain access for support since regulation and control of staff is viewed to be the most important job of the manager.

[24] This may have been due to criteria not being accessible to RNs via employers' staff intranets, and no hard copies of policies that listed the criteria.

It appeared that in comparison to SA WRNs, **UK WRN**s, when/if they had an appraisal, were more open with their managers when discussing PPD activities and asking for support. This may have been because, for academic study in the UK, women can study on a module-by-module basis until they gain enough credit to gain an award. Hence, an NHS employer can offer support for many RNs to study a module, (not a course). Whereas in **SA** WRNs studied a whole course, which was much more costly, as these courses were often full-time, over a period of six to twelve months, and thus there were less places and so in comparison to **UK RNs fewer SA RNs** received support.

6.2.6 Access to CPD study days

It was apparent that **SA** WRNs had conversations or/and made assumptions about their manager's approach with regard to accessing the SA government initiative that offered RNs three CPD days per year[25], which RNs were required to get their managers permission for (Public Service and Administration Department, 2009). This governmental initiative aimed to demonstrate to NHS staff that they supported PPD. The findings were that some WRNs accessed these days, whereas others spoke of their managers attempting to refuse them permissions to access these days. Hence these findings showed the **SA** WRNs experienced their rights being taken away from them, and some regained power by excluding employers from their PPD, turning it into a private affair of which Pilcher and Whelehan, (2017) argue gives women freedom to do what they wish without control from others.

Other **SA** WRNs spoke of challenging their managers, viewing it as their right to access the "exam day" (CPD day). Hence, although the SA government implemented an initiative to promote PPD activity by granting CPD study

[25] These are sometimes referred to as exam days

days for RNs, this study suggests that automatic access was removed by individual organisations and/or managers who had added in their own criteria limiting accessibility to this scheme. This was another example that brought WRNs to perceive that employer-led PPD was about employers and managers using their power and control to manage and limit their PPD.

6.2.7 Bonus systems

The bonus system was first offered by **SA** private employers and then adopted by SA NHS employers (as a part of their recruitment and retention strategy). It was found that this bonus system impacted on WRNs' perception of what they perceived as employer-led PPD. Once again, those who were successful and gained support from their managers had positive experiences, whereas those that did not get support, had negative experiences. Indicating that without managerial support success would be drastically reduced.

Unlike the **UK**, as part of their HR policies the **SA** government had a criteria that aimed to award RNs bonus monies for the two levels of performance described as *"perform significantly above expectations"* and *"outstanding performance"* (Public Service and Administration Department, 2007, p27). To apply, the requirement was to provide written evidence of knowledge and skills used in their jobs over the past twelve months, as well as any courses or academic qualifications achieved. For some bonuses, evidence included managers' statements of competence.

Several of these women who had successfully applied and received bonuses declared they used those monies to pay toward their studies and perceived their experiences of applying and having their manager's support. They spoke positively of this reward system in that it motivated them to focus on seeking and recording their evidence.

Those who had the knowledge, skills and ability to write in English spoke of the process of application being relatively easy. Some argued there was little

competition due to the higher academic level at which they were studying and the qualification that they would gain would, in comparison to others in the workplace, put them at an advantage.

For those who applied through the bonus scheme and were not successful in getting it, perceived it negatively, arguing that it was an unfair and discriminatory system, citing reasons to not having support from managers, finding it hard to write about their achievement and experience, and had difficulties in writing in English. Again, it reflected back to the lack of support on writing the application and managers making decisions behind closed doors "as to who would get the bonus – brown envelope". But also the lack of feedback offering constructive advice on to how they could get support for future applications was missing.

Hence, these findings could suggest the two systems (the CPD study days and the bonus system, both of which **SA** has been put in place by the government with the aim of supporting RNs' development) appeared to be undermined and reshaped by employers and/or some managers who, several WRNs argued, re-wrote the rules, which was perceived as using an authoritarian rather than a democratic leadership style.

RNs need to continue to challenge managers if they are not given access to use CPD days. With the bonus scheme, writing an application depended heavily on their manager's advice (which from the results of this study could be unhelpful, inaccurate, or very helpful). For several women, not getting bonus monies had serious consequences, as they could not self-fund their studies because they had no other way of paying fees and were therefore denied the opportunity to develop themselves and their careers which inadvertently effected their private lives.

The **UK** women did not state that their employers offered any bonus schemes for nurses which was to be expected as all of the UK WRNs were employed at the time by the NHS, which offered a salary progression scale,

with no bonus pay scheme. None of them referred to the experience of working within the private sector (NHS, 2016). A review of the UK main private healthcare employers' websites revealed that only one private employer offered an annual bonus scheme; however, this was not linked to the appraisal system or personal performance (Spire Health Care, 2016).

The majority of **UK** private healthcare employers did not offer a bonus system; they did offer holiday pay and sick pay, but fewer days than NHS contracts. They also like the NHS offered pension schemes and what they termed "a competitive salary" (BMI Health Care, 2016; BUPA Cromwell Hospital *et al.* 2016; Care UK Health Care, 2016; Four Seasons Healthcare, 2016; Nuffield Health, 2016).

No healthcare employers in **SA or the UK** offered any bonus pay for completing a specific qualification which is concerning as it demonstrates what the RCN (2020) argues is lack of recognition by employers. However several SA WRNs raised this in their applications for bonus and in their appraisals.

A review of the SA private employers' websites did not offer detail of their bonus schemes or to how many RNs could be successful in anyone time to receive the bonuses that would support PPD. Some websites declared that they ran a reward and recognition programme, but did not detail any further information (Medicross, 2016; Netcare, 2016) whereas others did not (Life Healthcare, 2016). The lack of information, detail and instructions could also add to the difficulties that WRNs have had when trying to apply for bonus schemes.

To summarise, women's perceptions and experiences with managers had a direct impact on recognising the WRNs having a view on what they perceived as employer-led PPD. Even those women who had positive perceptions and experiences were aware of the lack of support experienced by others. Most compelling was that, women who gave examples of managers who had

supported them in their PPD activities, recognised they "had been lucky", but also perceived the difference in what employer-led PPD was in comparison to their own perceptions of PPD and therefore had learnt to undertake PPD that satisfied both.

6.2.8 Gaining qualifications working at a higher grade but not getting paid

The findings of this study discovered that four women (**SA and UK**), on having gained qualifications, had not been treated fairly by employers. It was found employers did not always honour the promises that they had made such as: on achieving their qualification/specialist course RNs would be rewarded by receiving an increase in their wage to match the job role and responsibilities that they had inadvertently taken on. In the event, employers stated there were not enough monies in the budget to pay them an increased wage, but still expected them to carry out job roles associated with a higher grade. Cazier *et al.* (2014) states that if RNs share similar values of their employer they are most likely to continue to work for them, if not job satisfaction decreases and they are most likely to leave, this supports the findings here for the two **SA** WRNs (both employed in city areas, with no family responsibilities) decided to leave and seek employment elsewhere to get paid what they perceived to be the correct salary.

Two **UK** WRNs, on gaining their nurse practitioner qualifications at Master's level, who experienced not being given an increase in grade (hence wage) as promised at their recruitment interviews were disappointed with their employers. However, they claimed to understand their employers' current financial situation whereby the budget was tight and accepted their argument that nothing could be done about it, hence still valued their employers.

For their own reasons such as family and home constraints, they were unable or reluctant to move to better paid jobs. One **UK** WRN spoke of regret for not requesting a revision of contractual agreements before she proceeded

with the current pay scale, in that she was not able to reap the promised reward of a financial increase in pay. This was a significant amount of monies for she expected to be paid on a band eight scale, but was still being paid on a band six salary[26].

Employers assumed that these women who are already affected by gendered nursing pay would continue to work for a lower wage, the RCN argue that this is still the case (RCN, 2020; Abbott and Wallace, 1990). In jobs that had more responsibility and required more knowledge and skills, than in jobs that they had worked in previously. The two **SA** WRNs who were assertive in challenging these decisions by stating it was their right to be paid professional wages argued that their employers were not respecting them by not treating them fairly and terminated employment with them. Hence they made it clear that they had entered nursing not "as a calling" or as a volunteer, they had earned the right to be paid the RCN (2020) argue that RNs that this is still an issue in today's society and is a route cause of low pay in nursing. Their reactions could have been related to SA's troubled history that has been dominated by racism and apartheid (Kangasniemari *et al*., 2010; Mashamaite, 2017; Marks, 1994, Appendix A).

The two **UK** WRNs perceived that they had little or no choice, because of their circumstances they had to "wait and see" if they would get paid a higher wage. They had weighed up their options of moving home, both of which they said would be too disruptive to their families. In contrast to the SA WRNs, they were more sympathetic towards their employers' limited budgets, and did not offer criticism as to the way the budgets had been managed, accepting far more readily their employers' reasoning as to why they could not increase their wages at the present time.

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[26] The difference between a top band six and band eight is roughly £4,800 (RCN 2017d, 2017e).

In comparison to the UK WRNs **SA** WRNs seemed to be more incensed about the employers' reasons that there was no budget to pay them; for them, this was personal abuse – they had not volunteered to work for free Kangasniemari *et al,* 2010) agrees with these WRNs sense of injustice. It could be suggested this reflects the history of women's' work in nursing of which RNs have had to continuously campaign for better pay (RCN, 2020; Abbott and Wallace, 1990) and the historical culture that still affects SA nurses today, that "the calling" was seen as a vocation (this was often voluntary work in which women would give their lives to help others) which clashes with the modern-day professional status of the RN (RCN, 2020; Mashamaite, 2017). They knew, by having looked at the pay grades on the NHS websites, what they could be earning and saw it as their right to be paid these monies (Department of Public Service and Administration, Western Cape, 2014). This difference in reaction may have also been because these **SA** women had self-funded their studies and wanted the money that they had spent on PPD to be rewarded via their wages. Whereas with the **UK** women, one had partly self-funded and the other had been fully funded by her employer and therefore were more resigned to the situation because of the support the employer had given towards their training.

To summarise, employers gave reasons of financial constraints to justify not paying women their expected wage increase, though agreed verbally, they did not provide written contracts to state higher wages would be guaranteed on gaining the qualification, bringing me to argue these women had been placed in a position of which they had no power. It took WRNs courage to challenge employers over pay. Due to their home circumstances some women did not wish to move home for a new job, whereas others could do this, finding employers who would pay the designated wage. These experiences added to why women perceived employers having a different approach to PPD than their own, and demonstrate that employers are willing to abuse women in these positions using the excuse that they have their

qualifications and as a reward they are now gaining better job satisfaction, to deflect from paying them their owed monies.

6.2.9 RNs jobs under threat: change of perception and attitude towards PPD

At the time of data collection the constant changes in the workplace, was a reminder that **UK** WRN's job security was under threat and was viewed to be more unstable than it had been in the past (RCN, 2015a). It was found as a result of this economic climate WRNs' perceptions and expectations of PPD had changed.

The **UK** women's experience was different to their **SA** counterparts. They had the constant reminder that services may change, and, as a result, job specifications and criteria for jobs were found to be changing. In addition to this, the types of specialities within their employing organisation may change or be discontinued within the service provision; hence, WRNs found themselves having to work in specialities that they had no experience in, thus PPD was greatly needed. Experience as a qualified RN was no longer enough to keep their jobs safe from threat.

Hence, the old NHS culture having a traditional 'job for life' ideology had changed in the UK (Timmins 1994). Replacing it was a range of thoughts, feelings and differing reactions from RNs to this 'new' work culture (RCN 2015a). It brought recognition that experience without evidence of engagement in PPD activities can leave WRNs in a vulnerable place; employers expected to see evidence of PPD activities.

Women also spoke about the discomfort of having to compete against other team members when having to re-apply for jobs. And the negative effect it had in fracturing the team's dynamics, some of which never recovered and changed the workplace environment. Worry and concern about having a job and staying employable was reflected in the RCN (2015) report. Hence, these experiences affected women's perceptions of what they saw as

employer-led PPD. This brought them to recognise that if they did not engage in PPD activities, with or without support from their employers, it may have a potential impact on future employment. It resulted in an increase of women applying to get support, of which only a minority were successful, again leaving women having to look upon their own personal resources (time and monies) to undertake PPD that would aid their professional careers.

The participants from **SA** did not have the same experiences as the **UK** WRNs. But they were aware of the threat of unemployment. This was being experienced by RNs in different provinces, such the North West and Eastern Cape, but not from the province where participants were recruited from for this study (Mayosi *et al.*, 2014; DENOSA, 2016). Hence, there were no WRNs who discussed the threat of unemployment, but it highlights the vulnerability of the nursing workforce, in which external forces such as economic and socio-political factors affect RNs' jobs and their pay (RCN, 2020; Cazier *et al.* (2014); Abbott and Wallace, 1990).

6.2.10 Employers' initiatives and decision making on PPD

NHS employers' decisions on how to manage education and training budgets for RNs' development were found to have an effect on WRN's PPD. Acting like a double-edged sword: on the one hand, the decisions that they made could enhance some WRN's development; yet, on the other hand, WRNs who had not been lucky enough to have the same opportunities as their fellow RNs perceived themselves to be disadvantaged.

For example, **SA** RNs employed on the specialist nurse grade as part of the government's initiative to introduce the OSD were seen to have more opportunities for support from employers in comparison to other SA RNs studying for the same qualifications after the implementation had happened. This was largely due to the government's quick implementation of the OSD in 2007 that led to what Ditlopo *et al*. (2013) termed the 'grandfather clause', whereby employees were given the grade without having the specified

qualification. This had resulted in the employer's push to get RNs to complete postgraduate diploma qualifications, as this was a requirement for their job specification and contract. It appeared that SA employers had placed priority in funding these RNs on specialist nurse grades to gain these qualifications.

It could be argued that this situation was comparable with the **UK**, whereby the government is pushing to create more ANP positions to meet the UK's health demands (Baileff, 2015). However, no **UK** women claimed that they were not getting funding because of NP training taking priority, which was expected, as the UK NHS had not stopped funding for other RNs, but were perceived to have reduced funding budgets.

Many examples demonstrate that the employers' approach to managing the training and development of RNs can lead to many RNs feeling that they have been disadvantaged, as they see others being given more opportunities. These experiences contributed towards perceptions of the inequality of employer-led PPD.

6.2.11 The benefits and rewards of PPD

Benefits and rewards appear primarily to be focused on rewards that were viewed to enhance and maintain the role of the RN (Jasper and Mooney 2013; NMC, 2015; SANC, 2018). This supported the stakeholders – the nursing regulatory bodies, NHS and healthcare employers – who regulate what PPD activities must take place to ensure that RNs are safe to practise and undertake core training. It was to be expected that the answers (which they gave) would be related to keeping themselves up to date and continuously developing themselves to remain proficient in their current jobs and to be able to re-register via the nursing register. For some, having gained academic qualifications, they could now apply for better paid jobs. All WRNs from **both countries** expressed the personal satisfaction that they gained from completing qualifications that would be theirs that they owned,

that "no one could take away". Women **from both countries** became emotional as they spoke openly about the benefits and rewards, on how it made them feel better personally about themselves, increasing their own self-esteem. Offering some understanding of why they treated gaining and holding a qualification as being a far greater personal reward than the need or want to gain a higher paid job would demonstrate their success and demonstrate higher status.

Women from **both countries** spoke about the pride their family members had in their achievements, and that, for some of them, they were the first in their family to achieve degrees and/or study at a university (in both **SA and the UK**). Celebrating their success was important to women and, for some, their achievements were linked to those who held a special place in their hearts.

Several confirmed what they had thought the rewards would be. Yet, for many, what they experienced as the benefits of undertaking PPD were far greater. Having an academic qualification, confidence and an increase in self-esteem was a common answer and had been raised in previous studies (Bahn, 2007; Pool *et al. 2014)*. WRNs from **both countries** spoke of how they had gained knowledge, and this is what had given them more confidence, as shown in Hughes' research (2005). It was found in this study that women elaborated further, that they had gained the confidence to speak up within professional working lives and in their personal and private lives outside of work. Others around them had noticed this change and complimented them on their increase in assertiveness. WRNs in **SA** gave explicit examples of how their hierarchical culture in the NHS led to RNs not challenging doctors' decision-making or other nurses' decision-making. Porter's (1992) study raised issues of women's experiences in the way that they are expected to behave at work. In that women need to challenge this. PPD was found to assist WRNs moving from being sub-ordinate to being pro-active by expressing their professional expertise, voicing their views and

feeling empowered by academic study to gain confidence, to question, share knowledge and skills, hence becoming assertive by disregarding subordination and using knowledge to influence nursing care. Gould and Allen (2009) suggest that the benefits of supporting RNs PPD would be an increase in job satisfaction, morale and by RNs know that they are able to provide a good standard of care, findings here demonstrated that being empowered and demonstrating agency was much more powerful than just job satisfaction.

Several women from **both SA and the UK** spoke of the benefit of acting as a role model to their children, by demonstrating to them Lifelong Learning (LLL) skills of studying and gaining qualifications that they thought would help their children in the future. This was also found in Edwards' (1993) research who said women felt that they were educating their children by displaying they had to "do their homework" hence this encouraged their children to do theirs.

Hence, it could be argued that the true benefits and rewards were more associated with WRN's personal and private lives than those gained within their professional working lives.

6.3 Main Theme 2 - Engagement, Aspirations, and Circumstances

Aspiration is defined by Rojewski (2005, p132) as something that represents the individual's goals when they have the ideal conditions to be able to achieve them. Domenico and Jones (2007) highlight women's work is generally lower paid than men's work, although there has been a gradual shift to more women in the workplace with fewer staying at home. Women's aspirations have started to become more visible; however, there is little research on WRNs' aspirations or career patterns. Hence, the findings on WRN's aspirations offer a unique contribution towards knowledge whereby aspirations were found to be professional, personal and/or academic. Domenico and Jones (2007) state that career aspirations are influenced by

factors such as gender, socioeconomic status, race, parents' occupation and education level, and parental expectations, and argue these can result in limiting women's aspirations. However, they do not consider how, for example, a woman's race, low socioeconomic status and role as a breadwinner can also influence women's aspirations.

Kinsella *et al.'s* (2018) research argues that not enough is known about RNs' internal motivations towards post graduate education, whereas Brekelmans *et al.'s.* (2015) research suggests that there are three main factors that influence PPD activities: motives, importance and of the conditions that the employer offered with the PPD activity. The findings in my study, to a point, replicated Brekelmans *et al.'s* (2015) findings with regard to the importance that WRNs placed on their PPD, and the motives that they had, as both had an impact on their perception of PPD. For the majority of these WRNs, this did affect the level of engagement in PPD activities. However there was no recognition in Brekelmans *et al.'s (2015)* or Richards and Potgieter's (2010) research of RNs adjusting their pace of engagement in PPD activity, such as increasing or decreasing engagement throughout their careers/PPD journeys as shown in the PPD Model (Figure 6) nor that other priorities took a much higher place in women's lives. Brekelmans *et al.* (2015) had raised the conditions offered by the employer which would support or not support PPD; would ultimately result in women deciding to either reject or accept to undertake PPD activities. Richards and Potieter's (2010) study on continuing formal education for WRNs suggested within their closed answer questionnaire, WRNs experienced barriers and the difficulties they may have encountered. However theirs was a quantitative study using a 4 point Likert scale to measure responses, that resulted in the findings lacking in depth. My study has provided this depth, that gives greater meaning and understanding of those difficulties outside of the work environment or the hidden costs of PPD (discussed in Main Theme 3).

Brekelmans *et al*.'s (2015) research suggested there were connections between importance, motives and conditions. They described the conditions as being what the RN perceived they needed or required from their employers to be able to engage in PPD activities. They did briefly touch on RNs within their middle age aiming for a work-life balance; however, they ignored the strong influence women's personal circumstances had on PPD (Main Theme 2). Circumstances can swing both ways; impacting PPD positively or negatively. It was found that, on the one hand, women's circumstances could influence the speed/ pace in which they engaged in PPD; yet, on the other hand, it could restrain, slow down or stop the pace and level of engagement (as seen in Main Theme 4). Women's circumstances were not just about focusing on work but more so on achieving a work-life balance: that is regarded as something very personal to the individual and their need for work time being balanced with time spent outside of work, activities and other personal considerations (Pasque and Nicholson, 2011; Price and Reichert, 2017). Circumstances were found to be wide-ranging, with some of them being unique to women, for example, pregnancy, IVF treatment, feeling mentally and/or physically unwell, feeling that "the time was right" having time available outside of work for themselves as individuals or within the other roles they held.

Brekelmans *et al*. (2015) argued their findings demonstrated if RNs thought a development activity was important, then they would be more likely to pursue engagement in the activity. Pool *et al.'s* (2016) study concluded that the motives attached to the activity influenced engagement. Brekelmans *et al*. (2015) found this also depended on how the individual perceived what the conditions would be (i.e. what the employer offered such as time, and funding) should they be willing to undertake these PPD activities. If the conditions were not regarded as acceptable by the individual, then they would not engage in the activity. To some extent, Brekelmans *et al*.'s (2015) research findings correlate with my findings. For example, there were women

who spoke of themselves and their families living in poverty; to gain qualifications that could lead to a better job and better pay, resulting in a better quality of living. However, what was missing from Brekelmans *et al.*'s

(2015) research was reference to women's circumstances that did not stay the same; instead, they were found to change. It may only take one or more changes to shift their perception as to what PPD had become important to them, within that point in their lives that may have been perceived as less important in the past. A change in circumstances could allow more room to compensate for the unsupportive conditions. The hidden costs of PPD (Main Theme 3) which follows had also to be weighed up, and deemed more manageable than in the past, for example children growing older, and needing less time and attention.

6.4 Main Theme 3 -The hidden costs of PPD and the techniques and strategies used to overcome them

In the emerging PPD Model (Figure 6) the hidden costs of PPD are shown to act as a barrier in PPD. Hughes (2005), Gould *et al.* (2007) and Stafford and Banning's (2008) research all highlighted there were issues that affected women's perceptions and experiences of PPD, which was also supported by studies on RNs' continuing formal education (Richards and Potgieter, 2010: Kinsella *et al*, 2018, Edwards, 1993). Hidden costs were found to be down to difficulties women faced when undertaking PPD activities. Key difficulties as already previously raised in the above cited studies were the lack of funding, short staffing, personal time was found to be precious to women, some had no personal time. All these difficulties were found in my study and could limit women's PPD. It was evident that the lack of funding affected women's morale and could limit women's PPD journeys. Key concepts of feminism are that the 'personal is political' and placing private struggles into the public domain, promotes knowledge which can lead to women gaining power and having ownership of this knowledge (Pilcher and Whelehan, 2017). These unique findings can raise awareness of the struggles that WRNs had faced

and share the successful techniques and strategies that were successfully used to achieve PPD.

The findings in this study show, that as WRNs reflected on the difficulties they had faced, for some WRNs it was the circumstances (Main Theme 2) they found themselves in that limited them from developing further. But for others, it was the hidden costs of PPD (not anticipated and anticipated) that really did impact their level of engagement in PPD activities. Hidden costs of PPD activities (Main Theme 3) were difficulties (or described as barriers), which had a direct impact on individuals, affecting them and their families personally and/or, for some, professionally.

WRNs spoke about the exhaustion of working as an RN and studying at the same time. They emphasised there was little time for them to recover and recuperate before they were back at work again. For example in **SA**, 12-hour shifts were common practice, and in addition, women had many other pressures. Stress and exhaustion that women experienced was also due to the socioeconomic constraints that they found themselves in.

UK RNs, more so than **SA** RNs, argued it was common for them not to finish work on time. This had a knock-on effect by reducing the time that they had left in their personal time to undertake study. For those that had caring and home responsibilities, children, and partners, they said returning home late from work caused conflict in the home, and, often, this disruption caused by returning home late resulted in little or no studying taking place at all. Edwards' (1990) research indicated that conflict was caused because partners did not want their women to change from what they previously did (re: gender-related caring and housework responsibilities) or to discuss what they had learnt/were learning from their studies because the effect on women was that their language changed as they started to display informed opinions.

The majority of WRNs were found to be responsible for managing and running the household. For many of those who had children they saw themselves as the prime carer; others (mentioned more so from **SA WRNs**) also cared for elderly members of their family, which was also found in Edwards' (1993) study on mature women students. It was these responsibilities that women had to manage, contributing to the hidden costs of PPD that impacted heavily upon them. Some of these hidden costs were mentioned in Edwards (1993) but the findings in this study were more extensive in particular financial costs, whereby Edwards' (1993) study was focused on women studying for full time degrees and most likely to have received some funding. For WRNs in my study who had to self-fund their academic studies, these hidden costs were only the tip of the iceberg. Work colleagues, managers, educators may not be aware as to how the combination of them altogether weigh heavily on women.

The findings revealed an extensive list of examples ranging from: Women were found to have to pay for others to care for their dependents (this includes boarding school fees in **SA regardless of class**) and/or domestic housekeeping tasks whilst they undertook their studies. Payment was in the form of monies, or as "invisible money". Invisible money was in the form of favours to friends and family members, which were owed and expected to be paid back in different ways at a later date. In **SA**, the majority of RNs work 12-hour shifts with little or no opportunity to work shorter hours to accommodate school hours, so for these women they were already having "to pay" for childcare. Some **SA** women, to develop themselves and earn better pay, had to live, work and study away from their families. Having already sent monies home, they struggled to pay for basic food and accommodation, meaning that they could not return home to their families on their days off for they could not afford it. So for these WRNs, these hidden costs and "sacrifices made" were a great deal more, than for those women that had families and friends living nearby. In addition to these women spoke

of the emotional costs and the guilt they felt when not being able to spend time with their children which corresponded with Edwards (1993) study.

6.4.1 Professional jealousy (PJ)

PJ was another term that sat initially within women's perceptions and experience of unsupportive attitudes and behaviours. However it came to light that these negative behaviours were based on the work environment that was found to effect WRNs' perceptions and experiences of PPD. Beatty's (2001) research revealed that one of the primary deterrents to PPD was managers not supporting RNs' PPD: RNs not being released from the workplace to engage in PPD activities, and managers not allowing changes in work schedules so that they could attend PPD sessions. This was also reflected in this study.

The phrase "professional jealousy" (PJ) was repeatedly used by **SA** WRNs. Yet, similar examples were given by **UK** WRNs, who did not use any phrase to label or describe what was happening/or happened. A search in nursing literature only indicated in advice and discussion articles that PJ is when a person of the same or different profession causes problems between themselves and another person (Peter and Flynn, 2002). Chen and Kristjansson (2011) argue jealousy is negative emotion whereby a person may feel envy, anger and indignation due to their perception of unfairness. Hence, the jealous disposition that some felt towards others could be displayed through attitudes towards that or those persons. That for those on the receiving end of PJ experience PJ as a hidden cost of PPD.

Analysis of the data raised questions if PJ, in some cases, was a misused term to describe something else for references made to PJ were made by RNs working at any grade. From the behaviour of line managers[27] to the

[27] From the manager who doesn't offer funding or paid time for RNs to undertake courses and gain qualifications, restricting RNs' PPD so that cannot apply for higher paid jobs, to the

whole team and/or individual members[28]. What some of these examples demonstrate is the effect of employers' lack of support has, on staff and organisational culture. As pressure mounts this can increase PJ behaviour which in turn has a strong impact on those who are trying to undertake PPD, and therefore PJ becomes a hidden cost. Common PJ behaviour included (regardless of the grade/status of that person) exerting reasons or "facts"[29] openly to everyone to state why in their opinion and others, that this individual/s should not be having these opportunities or to be undertaking PPD.

Hidden costs of PJ is that the individual "on the receiving end" of PJ behaviour experienced, frustration, anger, despair and sought to find a way get around or through barriers that prevented them from engaging in PPD (with some WRNs not even bothering to do this, as their perception of PPD WRNs in this study told me that it was limited). Some WRNs gave up at the first hurdle, whereas others were far more determined to engage in PPD activities and sought ways to overcome them.

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manager who won't support the RN in their studies not allowing them: not allowing a change of working hours to allow them to undertake their studies, to telling the individual RN that they are not capable nor it is not appropriate for them to undertake these PPD activities, and/or it is not identified as a service need, and for **SA** women having access to the CPD days denied.

[28] Some team members question, why should that individual have these PPD opportunities, when others in the team haven't been given the same opportunity? To reminding them of the effect that it has on the team when they are absent, e.g. they are already short staffed. Or making comments that they had to put less effort to into their studies, because others had many more challenges to deal with, hence attempting to devalue the individual's achievements.

[29] What was commonly raised by WRNs in SA and the UK was RNs who exerted these negative behaviours often made similar comments in relation to: the number of years that they had loyally worked for the employer that should had led to them and others getting support disagreeing that that individual should get that support. This was regardless that they had not made any attempts to apply for any courses or funding themselves.

It could be suggested that the worst and most damaging PJ behaviour is displayed when team members or managers actions have/had deliberately attempted to stop WRNs from undertaking PPD activities or/and discouraged them from applying for higher graded jobs, regarding them as a threat rather than an asset to the organisation. Displaying as Chen and Kristjansson (2011) report as jealousy through their feelings, or attitudes and disposition. Nonetheless, several WRNs from both **UK and SA** spoke of having committed to undertake PPD activities. They began to experience a change in relationship between themselves, managers and some team members which came at a personal cost to them, as it changed their approach and views. Some experienced a breakdown in friendships and lost trust in others, finding themselves feeling even more isolated.

To summarise, the findings revealed a number of perceptions and experiences that acted as a barrier against WRNs' PPD. Some of these were stemmed from the employers' approach and how managers were told to manage these issues which was viewed as negative behaviour. Though, a minority of these could have been perceived managers and colleague's behaviour as PJ. This behaviour could also slip under the guise of bullying, of which the RCN argue is still prominent in nursing (RCN, 2020). Both experiences need WRNs have a place to be able to voice their concerns, and to seek support that will help to overcome them (RCN, 2020).

6.4.2 The hidden costs of PPD on women's relationships with male partners

Less than half of the WRNs in this study spoke of the positive support that women received from their partners, who took over the roles that women had by caring for children and doing housework. However, for many, it caused conflict in the home between other family members, including partners, who had agreed or did not agree to undertake responsibilities previously owned by women. Beatty's (2001) research findings stated that one of the difficulties cited was non-supportive spouses, but they did not elaborate any further.

Edwards (2013) research indicated that reasons behind this were partners having less time and attention, studying taking up space within the home and the threat that educational success would lead to independence. Women spoke of their partners expressing resentment and showing no interest, stating the studying that they carried out at home had contributed towards a break-up of their relationship. This was something that they had not anticipated for they had seen themselves as doing this studying to improve their family's quality of life, not reduce it. Edwards (1989) argued that the key for women was communication and emotional support without domestic inequalities that had previously been accepted as a trade-off, for it was women's personal choice and decision to study that was no longer accepted by women if they did not get support. What differed for some of the WRNs in this study was they had no choice but to undertake PPD, which impacted their approach towards PPD.

Four women from both countries indicated experiencing an increase of physical and/or mental abuse from their partners, who did not like the changes happening in the household: women had less time to carry out housework and caring roles, as they focused more time on studying. Edwards' (1993) UK research on mature women students revealed in her study of 30 women who had partners, 10 experienced a breakdown in relationship during and shortly after completing their degree. Her research revealed as in my study that physical abuse, mental abuse and verbal abuse was also experienced by a few women of different race and class. Though it was not clear in my study to if these women had experienced this prior to their studies, it came across that PPD had exacerbated partner's abuse. For me, these represented the un-anticipated hidden costs of PPD, which brings me to question would WRNs really have undertaken these PPD activities if they had known to what extent the consequences would be? None of these WRNs spoke of predicting the difficulties that they faced, nor that they perceived by undertaking PPD it would mean a break down in their

relationship with their partner, not even those SA women who had ex-husbands still living in their homes. This was another unique contribution to knowledge, in which in-depth insights have raised hidden costs that might otherwise have remained invisible. Several WRNs predicted prior to PPD there may be some small costs, but not the un-anticipated hidden costs and the impact that this would have on them. This is why it is important to share knowledge of the strategies and techniques used.

> It was noticeable that more **SA** women than **UK** women reported unsupportive behaviours from partners/ ex-partners in the form of mental and physical violence. The South African government acknowledges that violence against women is widespread arguably more so in the black culture (South African Government, 2018). Race is a complex variable, particularly in SA, given the apartheid past and fragmentation of identities (Seekings and Nattrass, 2005).

Black **SA** women explained that though their relationship had broken down it was common in **SA** for black women to sometimes not choose divorce. Reasons for this were complex, linked to class, race, community and family expectations and values (King and Hill, 1993). For many women, their husbands/ex-husbands still lived in the same house: they did not work, earn any money or take any responsibilities in the home or for caring for children. However, these men wished to be regarded as heads of the households and attempted to be in control and hold power over the family. **SA** women explained that the men felt threatened, their fear being that "their woman", by bettering herself, would change, and should she want to leave him, she could because she could afford to do so. This was not found in my study. However Edwards (1993, p116) suggested in her UK research that this was also the case, arguing that the change in students from having carried out further study included having informed opinions and '*an independence of spirit that*

could threaten their partners'. Further education leads to women having informed opinions (Edwards, 1993), and qualifications could lead to potential financial independence to better paid jobs, and a step away from poverty (King and Hill, 1993). Women's needs and desires to do PPD and to experience the hidden costs were much more apparent with **SA** than **UK** women in terms of time and difficulties with partners and ex-partners. Women may have anticipated that there would be some reaction from their partners/ex-partners, but to what extent could not be answered.

6.4.3 Strategies and techniques

Women experienced many difficulties when undertaking PPD, yet when exploring the literature there was very little that revealed to what WRNs' strategies and techniques were and why they had adopted these in the first place (Chipchase *et al.*, 2012). Piercy cited in Forster and Sutton (1989, p114) asserts that women may have experience but if there is no name in the vocabulary they cannot handle the experience. *'Once you name something, it exists for you, you can handle it in your mind, you can turn it around, you can decide what to do about it'*. Findings in my study led to naming some of these strategies and techniques which could provide new knowledge that promotes women's agency by giving them knowledge of the ways to initiate action that could assist with their engagement in PPD. The strategies and techniques first identified were based on studying, studying in the home, and negotiating with others in the household. This then led to other strategies and techniques focused on funding and support.

Pool *et al.'s* (2016, p28) study aimed to find out which activities motivated RNs' continuing development arguing that to encourage development, employers should undertake careful selection of activities that RNs would be most motivated to undertake but which *'cannot compensate for the lack of interest or participation'*. Pool's *et al.'s* study did not acknowledge why RNs presented themselves as having a lack of interest or participation. The results in this study provided more insights and many examples to why

WRNs had not engaged in PPD activities, above the minimum level. Many had stated that during certain times in their lives other things took a far higher priority, which left no time to carry out PPD outside of paid work time, an important factor not raised in Pool's *et al.'s* study. What was revealed in my study was the perceptions women had of what had affected their level of engagement, so offering greater insight.

Several women argued that they became an RN to do "hands-on" nursing, some viewing themselves as "not academic". Hence on completing training which they found hard, they had not expected to have to undertake further academic studies. Some did not lack confidence in their performance as an RN[30]; what they were lacking was confidence in their own abilities to undertake PPD activities that involved academic courses this was also raised in Burrow *et al.* (2016) review of literature on part time study.

Edwards (1993) argues many women are already 'time poor'. These women found studying and writing essays hard for they did not have study skills required for academic study and as a consequence it was very time consuming, which was unaccounted and impacted on other areas of their lives. For some **SA** women, not writing in their first language was also challenging and very time consuming.

Those women who had schooling that did not involve the use of computers and IT saw themselves at a disadvantage in comparison to their younger colleagues. Consequently, they had to spend much more time learning these new skills, two women from both countries spoke of the embarrassment they felt of not having these skills, which may have influenced the approach they took. The strategies and techniques to overcome "not being academic"

[30] Studies on RN's formal education indicate that confidence and self-esteem within the job role is increased on having carried out formal education, however they do not divulge into any further depth Lee (2011); Pool *et al.* (2016).

or/and not being IT literate were found to be: to pay others to type their essays (for example Ward Administrators that they worked with), or/and ask friends, partners and their children to give them time and teach them how to use the computer. For others, their approach was only focused on "getting the task done" regardless of the costs, and so did not necessarily gain as many new skills that would aid their PPD.

Edwards (1993) raised the issue of geographical space that was needed in the home to undertake study and places to have books and folders in the home. Many WRNs said that they needed to have space to study, space in the sense of mentally having space to think and space in geographical terms. Most of the WRNs in the study took full responsibility for managing their households, of which Fox (2015) agrees is common for women. Hence, they worked in professional jobs and came home to undertake what Hochschild and Machung (2012 called the "Second Shift"), whereby women hold their main paid job along with their other unpaid job as homemaker. My findings revealed that a "Tidy house, tidy mind" was what women saw as a priority. Edwards' (1993) study concluded that women felt that to be organised was the answer to combining study and family. The results from my study agreed with this and found before undertaking study in the home, women's strategy was to have the house clean, tidy, organised and this left them with "space in their minds" so that they could concentrate on their studies. Meanings behind having a clean and tidy house went far deeper, for it portrayed visual messages to others in the home - that though they were studying, "nothing had changed in the home" suggesting it was employed as another strategy such as to avoid conflict with others in the home.

Several WRNs spoke about having no available space in their homes to undertake private study sharing the strategies and techniques that they adopted to overcome the lack of space. Edwards (1993) argued that it was common for women to not have their own space especially if they had families. Four women from both countries with older children undertook study

in the same room at the same time; hence, the activity of studying was shared with family members both of which shared similar findings with Edwards' (1993) study, although two argued they found it too distracting. However, in this study a few spoke of using the dining room table – they claimed half of the table for study materials and allowed the other half to be used by others. What was new in my findings was that these WRNs argued that the visibility of seeing their study materials on the table, reminded them and other members of the household that they needed to undertake studies which also signified they needed space to be able to do this. It worked as an effective strategy, as it reminded others in the household that they needed their support to study without disruption, appearing to shift a woman's PPD from individual responsibility to the household's responsibility. This gave others in the household, permission to support women in their studies by encouraging completion, and to invite those in the household to volunteer to undertake household tasks.

Women expressed that it was important for them to have plans in place that were agreed by everyone in the household, so that they could concentrate on their studies which concurred with Edwards' (1993) findings. **SA** WRNs who were having to live in nursing homes on hospital sites whilst studying on their six-month or one-year course said that the advantage of this was they had less distraction and could focus more on their studies – decreasing the risk of failure, and creating geographical and mental space for themselves. Hence, their strategy was to undertake negotiation with family and friends prior to commencing the course[31], to ensure their homes, children and elderly family

[31] These negotiations extended further, to when the study had been completed. For example, the favours to be returned to those who supported them this include time, monies and other commitments. This element of negotiating support outside of work, extending past gaining or completing a course is not acknowledged within previous studies.

members were cared for. The hidden costs were that despite attempts to organise and gain agreement, at times it still caused stress and conflict.

These strategies were not a 100% effective in freeing them from their roles in the family. Yet members of the family "back home" had to take responsibility to care for those in the family home, because they were not there to do so.

Having the geographical space was raised again as an effective method by WRNs who found they had to go away from home to undertake study, so as to be least likely to get distracted (household chores and childcare were commonly cited). Edwards (1993) stated that a few of the women in her study tried to organise themselves and their households by creating timetables detailing the responsibility of household chores. However discussion as to how negotiation was managed was limited, which were new findings revealed in my study.

Women used a range of techniques and strategies, to allow themselves permission to try out new learning and/or gain support from members of their households. The "having a go" technique was found to be used by women who either viewed themselves as someone who would struggle to study successfully or/and by women who had responsibilities at home and needed support from their friends and family so that they could focus. "Having a go" was a phrase used that in some way allowed women to express and predict that they would find it hard, and take the risk that they may fail, but they would try, and see how they got on. For some individuals, this also involved secrecy, which led to silence discussed later in this chapter.

"Having a go", for some, was a strategy used to explain to members of their household that their PPD activity would be a "One-off" occasion, whereby for example other members of their household would have to be convinced to undertake chores to support the women's studies. For some women who gained confidence in their abilities to study modules or courses successfully, they moved away from the "one off" technique by asking family members to

continue extending this support, so they could continue studying to complete a whole course of study. This was successfully executed as family members took on new responsibilities in the home which became integrated as normal everyday life. Interestingly two women said their partners' attitudes shifted. Their opinions were sceptical at first to actively encouraging study as they could see the positive impact it had on them, and partners had pride in them when they completed their programme of study. Edwards (1993) only spoke of partners who were either supportive or non-supportive. My research demonstrates how women became skilful in negotiating ways to access support. However there was also evidence of women who were unable to overcome resistance by those who oppressed them.

My findings further demonstrated many women from **both countries** referred to their mums as being their biggest supporters. It was discovered mums played a powerful role in encouraging and supporting their daughters whilst they were undertaking PPD activities. Potter's (2003) study on young women in Higher Education (HE) and the difficulties in accessing funding for tuition fees, highlighted mothers understood the values that their daughters placed on PPD and they too had similar values. That mothers mediated use of their social, cultural and economic capital to enforce their daughter/s access to HE so their daughters could achieve what they had or would have liked to have achieved. Findings in my study demonstrated that in addition to this, mothers acted as role-models towards their adult daughters. Lee and Bauers' (2014) research found grandmothers undertaking baby siting did this because they felt that as part of their parental responsibilities, they must support their daughters and by doing this it would aid their daughters' wellbeing. Women in my study spoke of their mothers offering space to study, undertaking household duties for them, and most importantly, offering emotional support and encouragement for their studies. These findings expanded on previous research, to show the important roles that mothers played in supporting their adult daughters' PPD.

Three women from **both countries** talked about being the 'lone solider' in that they found the PPD experience isolating, often when studying for a part-time course without an established study group. Several spoke about not being able to socialise or see friends and the effect that it had on those friendships, some of which women deeply regretted were lost due to their studying. Others spoke about not having the time to meet with others, as home responsibilities resulted in them needing to be at home. These findings concurred with Edwards (2013) study which spoke of women being disassociated from others.

Those who were studying in a group, contacted their peers using a range of social media and text messages through their mobile phone which gave them support and also a place to discuss any difficulties. **UK** women studying in a group spoke of using their computers and mobiles to access student Facebook groups they had set up themselves. **SA** women who had to relocate to undertake study spoke of the supportive text messages from work colleagues, family and friends, and from social groups such as their Church. None of these WRNs spoke of using Skype. In **SA**, not all women could afford to own a new computer. Many places in SA do not have landlines; mobiles are seen as a much cheaper alternative for keeping in contact with others, particularly when they are unable to afford internet connections for computers, mobiles can be used whilst travelling.

Studying late at night whilst everyone was asleep was found to be common with women from both **SA and the UK** who had children. Three **SA** women spoke of working all night and then going to work in the morning, because they just did not have any time spare to study. This meant that they could spend time with their families and caused the least amount of disruption to their family's routine - reducing conflict in the home. Edwards' (1993) research had suggested women students who studied late at night, meant that by the studying not being visible and homes in order, their partners did not have to face up to the fact that their partners were studying on a degree

course, suggesting that women attempted to have two separate selves: the student self and the woman self. My study found women placed their children's needs above their own, such as children taking priority to use the only computer in the home (many could not afford more than one computer in the home, attempts to negotiate times to when and who could use the computer did not always work well causing conflict). The hidden cost of using this strategy was that these women were tired when studying late into the early hours of the morning, and did not always produce the best standard of work (hence a higher risk of failure), but they could not see any other way around this problem. They found it to be the most effective way to achieve studying, with the least amount of disruption or conflict within the home.

6.4.4 Other types of strategies and techniques focused on getting support and funding.

Other types of strategies and techniques were focused on getting funding and support from employers and from other sources. The strategy of taking study articles and books to read at work when quiet was used by two WRNs from **both countries**, which was dependant on their job role that had quiet time and also on their managers and team attitudes towards PPD. This strategy was suggested by Chipchase *et al.* (2012) which at first seemed unrealistic, as the majority of WRNs said this never happened in their workplace. However, three WRNs spoke of being encouraged by their supportive managers who gave them, when the opportunity arose at work, to take study during paid working hours.

6.4.5 Forewarned is forearmed: getting funding and support for PPD activities

The saying 'forewarned is forearmed' holds true for WRNs in this study (**SA and UK**) who had learnt from others' experience. By using this knowledge, they made decisions on whether or how they would tackle the difficulties they faced when undertaking PPD. This was the most insightful of my findings, as the review of literature did not reveal that women perceived that talking to

each other and seeking advice was very important, though it was apparent that women did so. It was predicted that the results would raise (as per the literature provided by employers such as the NHS), that WRNs would express that using the appraisal system and seeking out their managers to ask them for advice would be found. But only a minority spoke of their managers offering encouraging advice, which indicated a big gap between the idea of a manager being supportive to the reality. This made complete sense because the managers would not have had their own experiences to draw upon. Four women from both countries named a nursing educationalist as influential in their development. Others argued that their strategy was to undertake networking, and this included building a relationship with training managers who were "in the know" and who gave them advice on how and when to apply for courses that was paramount in aiding their success.

It came to light that there were many interpretations to what if any funding could be obtained by SA WRNs. One of these interpretations was that by having white skin, meant that they would not gaining funding via the local university to study a PhD[32] because the BEE principles of being those with dark skin would take priority over those with white skin. A review of the SA universities' websites funding schemes did not indicate that these were based on racial lines (Witwaterswand University, 2016; University of Africa, 2016; The University of Cape Town, 2016). What it did reveal was that many PhD courses were generally funded as full-time study, though some offered part-time studies. Grants/bursaries were given to students who had a lower level of income. A SA woman working part-time as an RN would most likely

[32] None of the women in this study spoke of applying for funding outside of their employing organisations. My own website searches conducted in the literature review on nursing unions, nursing organisations and university sites revealed very few opportunities for SA. Difficulties SA RNs face when trying to obtain funding other than their employer may be greater than those in the UK. This may be because funding is being primarily offered to those who are in poverty (The University of Cape Town, 2016) employed working RNs are viewed as not living in poverty.

have an income that would not be classed as "poor enough" to receive a needs-based bursary. More importantly, it was noted that there were no specific grants aimed at RNs to access. This meant they would have to find the monies to pay for the fees or to get a loan from somewhere else.

Whereas in the UK, there were many more opportunities for funding through scholarships, bursaries and awards. Hence, the findings recognised women were having to seek monies to fund PPD. Yet, none of them had used the strategy which was to research the internet or apply for funding outside of their employer's funding schemes. These findings demonstrated women were either unaware and had no knowledge of employers' training and education budgets and funding schemes worked or unprepared to look for these resources. It is crucial to explore further what prevented women from using this strategy? As fewer women receive support from employers, some women, due to their circumstances, will not be able to self- fund their own PPD activities. For **SA**, it is essential that nursing organisations advertise this strategy and educate women on how to search, apply and understand funding processes and that they take responsibility to create funding schemes to aid RNs PPD. Women from **SA** spoke of having family members lending or paying for their studies. This may be because SA women have fewer opportunities to get loans in comparison to men (Department of Women, 2015). **UK** women referred to how much money they had spare at the end of the month to pay for course fees and none of them spoke of getting loans from other members of their families, more so their negotiations with managers to get funding.

6.4.6 Using portfolios to aid PPD

The literature review raised portfolios as a strategy to aid PPD (Redfern and Hull, 1996; Rosser and Jasper, 2013; NHS Scotland, 2018). Redfern and Hull, (1996) discussed the rationale behind RNs having a portfolio and using the portfolio as a tool to record and self-assess PPD activities that would also be useful evidence for re-registration. They argued portfolios were a powerful

motivator, and that mapping one's progress and reflecting on experiential learning increased self-esteem. One of the questions asked during my research interviews was: 'What action, activities, techniques and/or strategies have you used to undertake professional development?' It was surprising that only one UK woman[33] spoke about using her personal portfolio as a means to regularly assess and record her progress and evidence, arguing that "You need to be proving you are doing it". Stafford and Banning's (2008, p181) findings stated that community nurses had used the KSF *'as a means to recognise possible CPD activities and develop portfolios'*. Their research was dated close to when the KSF had been recently introduced and KSF portfolios were available (i.e. 2008); this may be why their research produced these findings. Whereas, in my study, the KSF and OSD had been in use for over ten years and were perhaps no longer in the forefront of WRNs' minds with no employers printing KSF portfolios for employees to use. The findings indicate that these WRNs (apart from one UK woman) were not using the portfolio as a development tool, nor were women in the UK abiding by the NMC's PREP requirements, that stated that RNs were to hold a portfolio of evidence.

Since collecting these data, requirements have changed for re-registration in both **SA and the UK**. The NMC (2011, 2016) has scrapped the requirement for a portfolio that would hold a range of evidence, and introduced a requirement limited to written reflections, whereas SANC (2018) are introducing a requirement for RNs to have a portfolio and record CPD points.

[33] One SA woman spoke of having two appraisals per year and having to present a portfolio recording her activities at these meetings to be able to achieve a bonus. The portfolios she used had specific instructions as to what evidence the private healthcare employer wanted to see, that evidenced the development and experiences of the employee. Not necessarily as a tool for personal career development.

Hence, both CPD systems will only require limited evidence of PPD activities, RNs will need to have some way of recording their working hours and their PPD activities, but many would be unlikely to use a portfolio. These findings and the literature on the CPD requirements from both the SANC and the NMC are concerning, or what it could indicate is that there is limited guidance available to WRNs with regards to their PPD and on how the portfolio could be used to enhance their PPD. A minority of WRNs from **both countries** had spoken about experiencing a manager who was keen to develop them, or/and had other role models who encouraged and guided them. Yet, the majority of WRNs claimed they did not have any of this support. Though women could access websites that offered advice on PPD (some of them having no financial costs; others were only for members of the nursing organisation or union that published these) none of them referred to them as a strategy. For some WRNs, it was their own aspirations that drove them to develop themselves and to identify which employers offered the best support for PPD.

The unique strategies that **SA** WRNs used were similar to their **UK** counterparts in that they changed employers in order to gain better support for PPD and better employment contracts. However, in SA this was from public (NHS) to a private employer or vice versa. SA has about 400 private hospitals that boast equivalent or higher standards than European hospitals, whereas the UK has a third of this number of private hospitals (see background information provided in Appendix A). Women were found to be weighing up the advantages and the disadvantages of working for public or private employers. This was an effective strategy for improving PPD opportunities.

The findings were inconclusive, but from the limited data collected they suggested that the private sector gave women a wider range of experience and access to engaging other informal PPD activities, whereas the public NHS offered support for studies to gain qualifications (time and monies), but

limited opportunities to gain further experience in the form of informal PPD activities to meet job specifications and managers appeared to limit what they could do. What was clear was that women working for private healthcare employers earned a higher pay, they were not restricted by line managers and job specifications. Compared with NHS job specifications, they were encouraged to have a higher level of responsibility and gain a wider range of experience, their performance was evaluated on a regular basis and they received financial rewards for their efforts in the form of bonuses. That these women were expected to keep recording their PPD activities as evidence for appraisals and bonuses.

6.4.7 Women's use of silence in PPD.

The PPD Model (Figure 6) outlines how women resist what they saw as oppression within the hidden costs of PPD. They used techniques and strategies to overcome these barriers. The findings revealed WRNs changing their behaviour as a result of the way that they felt and/or experienced about how employers, managers and/or other members of the staff were treating them. Silence was used by women in many different ways.

The findings showed that a minority of WRNS were moving silently. Silence was initially seen as a strategy that women used to avoid any conflict, or any further conflict, with others. Malhotra and Rowe (2013) postulate feminist literature asserts silence is used to oppress others, by silencing women it gives oppressors power, hence there is a relationship between powerlessness and silence. In western culture it is viewed by feminists that silence must be activated into speech to be able to resist and transform conditions of oppression. Yet Malhotra and Rowe (2013, p5) also point out the advantage of silence is that it; *'allows space to breathe … allows freedom of not having to exist constantly in reaction to what is said … and to go within before one has to speak or act'*. This rings true with my new findings in which several WRNS from both **SA and the UK** learnt that keeping silent about

their PPD activities was an effective strategy that meant they "could not be stopped", nor could any attempts be made 'to block' their PPD activities.

Reasons behind this use of silence were varied though pointed towards women feeling powerless. For the majority, anger and frustration against their employer's lack of support for PPD activities and lack of interest in supporting WRNs' career development appeared to fuel these actions. To carry out PPD activities without their employer's knowledge made it appear that they were fighting back against oppression and regaining power and personal pride. Two of them said it was because of their manager's lack of support and attitude towards them (as raised in the discussion on managers and appraisals) in that managers told them they did not think they were capable of doing these PPD activities successfully or that they thought their managers saw them as a threat. Some were given the impression by their managers that they did not wish them to undertake PPD activities.

Several wanted to see if they could do PPD, without other people having the knowledge that they had done so. So, if they failed, they would not have others judging their failure or have the knowledge of that failure, which could taint their reputation and be used to assert their power over them. Lastly, two said they wanted to gain their qualifications, apply for a better job and then to have the satisfaction of leaving their current work environment, surprising everyone, including their managers (who did not believe that they could gain qualifications), with their achievements and new job role of which they would no longer hold any power over them.

The silent movement of women was used for many differing reasons. This was more visible in the data collected from **SA than in the UK**. This silence continued into the home, whereby only one other person would know about their studies, or maybe a few friends. These women were also unwilling to

risk others finding out.[34] It could be concluded that silence is used as another strategy for WRNs to retain power and control. The use of silence reflects the negative culture that women still face inside and outside work, that women have continued to take risks to do PPD, despite the opposition that they may face.

6.4.8 Nursing, PPD and phoning in sick

The physical and mental exhaustion of the job has already been raised as a deterrent towards PPD and one of the most common reasons for RNs being off sick from work (Lamont *et al.* 2017). Phoning in sick to work was raised by **UK** and **SA** WRNs who though they had no proof they thought that this was being used as a strategy by RNs to undertake PPD (often work required for academic essays). In the **UK** it was argued if RNs went off sick when they were studying on academic courses, it was purely down to poor organisation, and a last-minute rush to complete their work.

Research studies by Lamont *et al.* (2017) argue that RNs worldwide have a high sick rate in comparison to other professions, and that this is recognised as a global problem. Individual and workplace factors are known to contribute to sickness, and that these can lead to sub-optimal health and wellbeing. RNs in Australia take what they call a 'mental health day', to step away from work and attempt to recover. Several WRNs were just exhausted by work and needed to take sick time to "catch up with themselves". Confirming their need to take sick time was focused on recovering mental and physically because they felt unwell. They needed to recover so they could manage the

[34] Incidentally, I spoke to a UK WRN who told me that her line manager wanted to record and discuss her progress on her degree and make it an aim on her appraisal document. The WRN's reply was she wasn't going to tell them anything. Because they did not offer her any support, therefore it was private and would not allow it to be recorded on her PPD. She used silence in protest to her employer's attitude towards her.

challenge of working and studying. Many WRNs were facing the hidden costs of PPD by having to use up their annual leave to undertake study.

WRNs from both **SA and the UK** were having to resort to using sick leave as a strategy for they needed to recover from work and because of the lack of support from their employer, they saw themselves as having no other options, but to have to use this strategy. These examples contradict the assumptions being made that this strategy was used because of the lack of personal organisation, and instead shines a very different light on the difficulties that WRNs face in **both SA and the UK**, which impacts directly on their personal and professional lives. What was apparent was that WRNs had changed their perceptions on employers who did not value the development needs of employees by not giving them time or other means of support to carry out PPD activities and/or support their career development. This caused a division between them and their employers, for loyalty towards whom? was questioned. In response their perceptions of their employer shifted, they decided to put themselves first, above the employer, and their place of work. They empathised that they needed to pass their academic studies for many reasons, including the financial implications to if they failed their studies, the impact it would have on them personally/professionally and their families[35] would be catastrophic.

6.5 Main Theme 4 - Women's PPD journeys

Women had different approaches to their PPD. This was one of the unique contributions to knowledge of the study, as it challenged conventional concepts of a career and outlined the unpredictability of WRNs' PPD

[35] This applied more so to women in SA who relied on monies from family members who lent them monies to pay costs associated with university fees, travel and accommodation. In this study two women spoke of failing a course, and the devasting impact it had on them personally, and professionally in that this effected their current employment contract.

journeys. What was understood as a career and how women's lives correlated with the theories on careers and PPD was subsequently explored.

A career could be defined in several ways. For some, working in the same company or types of jobs is a career. For others, such as in nursing, it is working in this chosen profession. Domenico and Jones (2007) state that career development should demonstrate progress, increased salary, and recognition and respect from colleagues. Theories on career development can be found to be aligned with the concept of life stages within a lifespan. For example, Super's theory (1990) is used to educate career counsellors: it suggests humans go through growth, exploration, establishment, maintenance and disengagement, that the 'rainbow' involves moving through eight life roles, some roles being more prominent within specific stages of the lifespan than others this theory is also supported by the ICN (2010). Super (1990) originally cited fixed stages within a lifespan – within his theory of a life career rainbow. Acknowledging in his interview with Freeman (1993) he had feedback from many women who argued that they did not view this to be applicable to them, that there are more complexities than originally anticipated between fixed career stages (Super 1990; Freeman 1993).

Ayres and Guilfoyle (2008) agreed life stage theories may be too prescriptive for women. However, these models of career development should be considered because they allow us to recognise the complexities between women's life stages, the development and experiences that women undertake in their careers and development journeys. Betz (2005) argued women's approach towards their careers has changed, as they no longer view their financial security to be situated within a marriage, relying on a man's wage that would be far higher than their own wage. Women are now preparing themselves so that, should they become or stay as a single woman, they can manage their finances and their lives independently.

Edwards (1993) argues the role of the male being a breadwinner has become less common in today's society and, as discussed in the background information provided in Appendix A, the number of female-headed households has increased. King and Hill (1993) also add that women's social mobility is more accessible as women has access to birth control, meaning that they can have more choice to plan when to have their families, and not to have children. Also, they have more rights to study and gain access to study. In the UK, the women's state pension age has changed from fifty-five years old to sixty-seven years old which may also have contributed to a change in women's careers and a change to approaching retirement and, may result in more women working post-retirement. Hence, the eight roles that Super (1990) suggested are no longer situated within one stage of life. For example, the role of student can no longer be situated only within a twenty-year-old's stage of life. Women held a number of roles, including the role of being a student.

In my study, the ages of the WRNs who had recently studied ranged from their mid-twenties to their mid-fifties. They were not in a stage of maintenance and preparing for disengagement; instead, they were at the stage of growth, situated near the beginning of the lifespan stages. It was because of this growth stage it made me question the use of the term 'career', as it assumes women travel through the eight stages in the order shown in Super's (1990) model. The PPD Model (Figure 6) demonstrates WRN's approach and engagement in PPD are complex. WRN's perception of PPD and their level of engagement can fluctuate throughout their working lives, hence women's PPD journeys are not as predictable as Super's lifespan stages suggest.

Pool *et al.* (2014) argued that little is known about RNs' development strategies (discussed in Main Theme 3), that influence RNs careers. They supported the theory that suggested age influences work-related motives. They had placed RNs in to three different age groups to represent stages of

working life: young (20-33 years old), middle (35-49 years old), and older (50-65 years old). They argued that their findings appeared to be related to development strategies and they attempted to find a theme for each stage of RNs' age groups. That younger RNs' strategy was to gain experience and develop their careers. Middle-aged RNs were aiming for jobs to be varied and interesting, with the desire to achieve a work-life balance. Older RNs were aiming for consistency and doing smaller activities. Though these stages could be representative of some women, the data collected contradicts the stages of working lives and supports the idea of women undertaking PPD journeys that are flexible and can change at any point, regardless of age. The findings in this research demonstrated that some younger RNs were planning for job roles they wanted to be doing in their middle ages, supporting Pool *et al.*'s (2004) findings.

This study exposes a unique contribution to knowledge, as it revealed WRN's PPD journeys were flexible, and many WRN's perceptions of PPD were changing throughout their lives regardless of age. There were younger women who were aiming to undertake PPD at a fast pace, using the strategy to gain experience and develop their careers. However, there were also middle-aged and older women deciding to undertake development activities at the same pace. For some, it was because their circumstances at home had changed, or their employers had agreed to support them in further studies, hence they could manage better, as the hidden costs of PPD had been significantly reduced. External factors and personal circumstances influenced WRN's PPD journeys. For example, one of the reasons behind **SA** WRNs wishing to study in their late 30s and 40s for their masters degrees was because they would then be in a position to set up and manage their own clinics (the pay would be much higher than in the NHS but they would also gain a great deal of professional autonomy, which was important to them). In the future, this approach towards PPD may also been seen in UK

WRNs as they address the challenge of having to longer due to the change in pensions.

Women from **both countries** expressed they were engaging in PPD activities because they wished to improve their employability, and several said it was to get a better pension when they retired. For other women, it was because, for them, "the time was right" to engage in PPD activities. Some women felt ready to take on a new challenge; this was regardless of age, and more based on a change in their personal circumstances, and/or a change or reduction of the predicted hidden costs of PPD. Perhaps, because these aspirations were viewed by women as personal and/or professional and/or academic development, this made it less likely for the pace and level of engagement in PPD activities to sit rigidly within Super's (1990) set stages of life or Pool *et al.'s* (2004) set ages of life and more within their PPD journeys.

It was found WRNs like myself had taken planned career approaches, as they knew exactly where they wanted to be and used strategies that were effective in reaching their set goals (other strategies used are discussed in more detail in Main Theme 3). They held a perception that they needed to take a fast pace in their PPD journey so that they could climb the career ladder quickly which could be argued as the more standard approach towards career development. This appeared to be a strategy which had also been advised by managers.

What came as an interesting discovery and a unique contribution to knowledge was that some WRNs from both **SA and the UK** commenced nursing with an unplanned career approach (with the only ambition to work as an RN). They used some strategies that led to an equally successful career in nursing as those who had planned their careers. This led to them undertaking another challenge. An example of this was self-funding of a module.

WRNs from **both countries** controlled their PPD journeys, making decisions as to when the time was right for them and, more importantly, when the time was wrong for them to engage in development activities. Hence, WRNs held the power to make decisions on their PPD activities. Some had turned down offers to undertake development activities, because they had not put plans in place that they perceived would support a successful achievement of the PPD activity. It was found some women perceived that these hidden costs of PPD, that others may not be aware of, would work against them. For example, gender issues, such as women's roles and responsibilities outside of work were viewed to be important in creating a balance in their lives. Without balance and support from their families, this was viewed to be too risky, placing their careers as being less important than others in the home (Betz, 2005).

Several WRNs shared the same thoughts, believing that, without planning, there would be a higher risk of failure, and they were not willing to take the risk. Hence, the pace and route that WRNs took in their PPD journeys varied from one individual to the next.

What came across clearly in the findings was the lack of support from employers that has resulted in WRNs having to stop or slow down in their engagement with PPD activities. Women who have little money spare or little personal time will not be able to self-fund PPD activities such as specialist and/or academic courses. Hence, the extent of growth and development WRNs can engage in, despite calls for equal responsibility between individuals and employers (APPG, 2016) and as McSweeney (1996) argues now lies more with to the responsibility and actions that individual women personally take, and less so with the employer.

To summarise Super's career development model (1990) and Pool *et al.'s* (2014) research suggest that there are specific ages within the lifespan in which career development activities are engaged in at a much faster pace

than other times in life, these can only be regarded as generalisations, and need to be applied with caution. As women's roles in society are changing, women recognise the importance of employability that will sustain them and them families. As a result, their approach towards work and their PPD continues to flex and change. Women's PPD journeys have been found to be far more flexible and somewhat unpredictable (sometimes due to socioeconomic changes) than these life stages make out, with the pace of engagement changing continuously. Employers and managers need to take this into account when considering WRN's PPD.

6.6 Summary

This Discussion Chapter has demonstrated that the study has answered the research question that aimed to explore and compare SA and UK WRNs' perceptions and experiences of PPD. What is now known is that there are complex dynamics between women RN's personal and professional development, that this can also be affected by their professional and personal lives. The findings have led to a new definition of PPD. The chapter has stated the major findings of this study, though the discussion of the Four Main themes, subthemes and the emerging PPD Model. The significance of the findings has been explained in relation to the existing body of knowledge on WRNs' PPD and the issues associated with them, identifying as to why these new findings are important to WRNs' PPD. The emerging PPD Model can act as a tool to aid WRNs' empowerment.

Chapter 7: **Conclusion**

This study aimed to compare WRNs perceptions and experiences of PPD in South Africa and the United Kingdom and to identify the ways in which women as RN's have approached their PPD. The comparison between the two countries, SA and the UK, led to findings that could be used to demonstrate an international overview of WRNs' perceptions and experiences of PPD. This chapter concludes with the main findings and completes by stating the limitations and recommendations that suggest what action could be taken in the future to benefit WRNs, managers, leaders, educationalist and employers.

As healthcare has evolved WRNs now have to engage and record PPD activities that demonstrate as part of the re-registration/validation process, that they are up to date with their practice (ICN, 2001; NMC, 2015a and b; SANC, 2017, 2018b). Employers need RNs to engage in core PPD activities as a minimum, to satisfy mandatory health sector inspections conducted by government and independent bodies (South African Government Information, 2007; Department of Public Service and Administration, Western Cape, 2014; NHSemployers.org, 2016).

In addition to this, there is an increasing demand for WRNs to develop themselves and undertake PPD. After gaining their nursing qualification, WRNs now have to study for further qualifications, often with academic accreditation, to firstly continue to work in their current jobs and secondly, to be able to apply for other roles above the minimum grade or for one of the many types of new nursing roles being created (NHS Scotland, 2018; SANC, 2018).

Having justified the importance that PPD plays within WRNs' working lives, this study aimed to understand and explore women's perceptions of the benefits and rewards of PPD; to explore in more depth the difficulties that women were facing and to identify the strategies being used to overcome

them including exploring issues of gender that affect women's lives and their PPD.

Women in this study had experienced the threat of having to re-apply for jobs, some advertised at a lower grade than what they were previously employed in. In SA, RNs have colleagues that have found themselves unemployed as heath care budgets were said to have 'run dry' (*Mayosi et al.*, 2014 and DENOSA, 2016a). Hence, women's approach to employability has changed. Women are recognising that even though experience is still valued within the workplace, job specifications are starting to place academic/specialist courses (and other PPD activities) as essential. So, without holding these qualifications, women now face the real threat of being unemployable, or being employed on a much lower grade, unless they act and undertake PPD activities to aid their employability.

The economic climate has affected healthcare service budgets. Demands on healthcare services are costly, and the pressures on budgets has affected WRNs PPD firstly by creating staffing issues that limits opportunities for WRNs PPD and, secondly, as education and training budgets have been reduced, remaining budgets are insufficient to support WRN's PPD. As shown in the findings of this study, PPD activities are no longer assumed to be funded by the employer or undertaken within paid working time. For many, PPD activities have over spilled into women's personal private lives.

The aims of this study were achieved by using a working definition of PPD; that it incorporates both personal and professional development to guide the direction of the research. Through to the development of a definition of PPD. In that the study concludes the definition of PPD is the need to grow and to continue to develop and learn. For RNs, PPD is about having self-awareness; keeping their knowledge and skills up to date within the speciality they work in, and with the latest policies and procedures of the organisations

they work for. This definition sets out clearly what PPD is for RNs registered to practise.

The findings resulted in the generation of the core Theme 1; women's perceptions, experiences, benefits and the rewards of personal and professional development. The adjoining Themes 2, 3 and 4 were, Women's perceptions and experiences of engagement, aspirations and circumstances that can influence and/or limit PPD, the hidden costs of PPD activities, the strategies and techniques that women used to overcome the difficulties, and Women's PPD journeys. All contributed to the creation of the emerging PPD Model. The development of the PPD Model has resulted in a model that demonstrates the relationships and interdependency between each theme and how these impact on women RNs PPD journeys. It is aimed to act as a tool for WRN's to use that can aid empowerment within their PPD.

7.1 Methodology

Constructivist Grounded Theory (CGT) which requires constant comparison of data and reflexivity was used to undertake the analysis, identify codes and to establish if these findings were specific to countries. WRNs who participated in this study were willing to meet and trust me by sharing their stories, answering my questions, and educating me about their lives. Rich thick data was collected for this qualitative study as a result.

The methodology used in this qualitative study was effective in gaining new knowledge to build on existing knowledge. The comparison of data between the two countries was examined and analysed through the constant use of reflexivity. Conversations with RNs to hold exploratory conversions, member checking with participants, field notes and writing a reflective diary all added to the process of deriving the data from the interviews and ensuring credibility and trustworthiness. Reflection was powerful in identifying the differences, similarities and contrasts between WRNs from these two countries. Without having undertaken a comparison, I doubt very much that I

could have found a way to present this knowledge in a preliminary model that could be used and understood to explain the dynamics of PPD within WRNs' lives and act as a tool for WRNs to use for their PPD. By using these methods, the study was successful in producing findings that can be used to aid WRNs knowledge and help empower them in their future PPD.

The literature review identified that there were definitions of CPD, and professional development but none for PPD hence a definition of PPD was established from these findings. PPD is the need to grow, to continue to develop and learn. For WRNs, PPD is about having self-awareness, keeping their knowledge and skills up to date within the speciality that they work in, and staying informed on the latest policies and procedures for the organisation that they work for. This definition encapsulates both informal and formal PPD activities, offering a definition that is applicable to all WRNs, regardless of whether they are engaging at a minimal or a higher level of PPD.

The core theme was Theme 1 - Women's perceptions, experiences, benefits and rewards which produced findings that answered the research question posed for this study. Informal and formal PPD activities were viewed to be important to women. Academic and/or specialist courses were viewed as formal PPD activities. Informal activities were seen to range from core training, mentoring and taught sessions to develop knowledge and skills. The findings indicated that WRNs had very few opportunities to undertake informal PPD activities that are mainly situated in the workplace. Core training was cited as inhouse, mandatory and/or in-service training. Very few WRNs spoke of undertaking other types of informal PPD of which was very concerning.

The findings revealed the difficulties that WRNs were having in accessing core training activities. **SA** women working in rural areas and women in the **UK** all stated the difficulties that they were experiencing which could impact

on nursing practice. I did not expect to discover that the time needed to carry out core training (including clinical training) to cause conflict in the workplace, whereby WRNs were having to resort to carrying out this training in their personal and private time. A reason for WRNs resorting to have to do this in their personal, private time was that without undertaking core training they were at risk of not being updated, and that this could impact on current practice. WRNs were resentful that, because employers did not manage these "short staffing issues", it impacted on them personally.

The quality of core trainings conducted in the classroom, within multidisciplinary groups was perceived on the whole by SA WRNs, to be good. However, it was a different experience for **UK** WRNs who disliked online learning programmes, arguing that they were poor quality and were designed to avoid releasing staff from the work area, hence containing short staffing issues. The result was that they reported that they learnt very little: carrying out these computer-based trainings within a busy ward environment de-valued the process further, turning this training into a "tick box joke".

Employer pay schemes (KSF, Department of Health, 2004a, 2004b; OSD, 2009, 2014) are now aligned with appraisals and job specifications that stipulate requirements for the role, and the development that must or should take place to ensure that WRNs have the knowledge and skills to run the service. Appraisals aligned to these should include discussion between the line manager and recorded on the RN's development plan that is aligned with the needs of the service provision. Findings in this study showed that WRNs who wanted to undertake PPD activities that were not viewed by managers to be aligned with service provision and their current job, were not supported.

To prevent further abuse of women and aid job satisfaction (and avoid the risk attrition of highly qualified staff) (RCN, 2020). It is recommended that employers take more action to demonstrate that they value WRNs PPD (Cazier *et al*. 2014). That they provide work contracts before commencing

formal study (these being regarded as essential qualifications for the job role and service they work in) that guarantees payment of monies on completing qualification/s that aid higher performance within the WRN's current and/or job role/s. That this could be acted on by either placing them onto the next level (increment) of their pay scale or offering a stand-alone payment.

"Short staffing" and the lack of resources were commonly blamed for reduced opportunities for development activities within the workplace (RCN, 2020). Many WRNs spoke of the apathy that managers showed towards the organisation that they worked for. On reflection, this brought me to question whether WRNs in this study viewed managers as being de-skilled in offering support and advice, as funding, paid time and other supportive measures had mostly disappeared from the workplace explaining why conversations about PPD were experienced on the whole to be negative. Only a handful of these WRNs had positive experiences of consulting and receiving constructive advice and feedback from managers on to how they could be best supported and how to successfully navigate processes of applying for courses, paid time and monies. WRNs perceptions included hidden rules created by managers that were used to prevent WRN's PPD, and some managers just not interested or did not wish for them to develop. Hence this has resulted in recommendations being made that support the Triple Impact Report (2016) that states that managers need to support and develop RNs.

The findings of this study led to a recognition that WRNs were found to have a perception of what they thought their employers perceived PPD to be. This differed from WRN's own perceptions of PPD: extending past the core trainings and development required to meet the service provision, women identified PPD activities that consisted of academic study and courses that would support future employment and career development.

In Theme 2 – Women's perceptions and experiences of engagement, aspirations and circumstances that can influence and/or limit PPD. WRN's

perceptions were strongly focused on the realities of the different levels of engagement that PPD activities required – some of which they knew would spill over from their paid working hours into their personal, private time. From these findings it was recognised that WRN's level of engagement varied throughout their PPD journeys. That WRN's circumstances were found to shift and change throughout their lives that these impacted directly on the level engagement and the choices that they made about their PPD and their aspirations. A change in circumstances was found to adjust women's approach to PPD. For some the lack of support from employers made them more determined to succeed.

Some women held aspirations to how they wished to develop that depended at the time on their own perceptions of PPD that could fluctuate throughout their PPD journey. That aspirations influenced the level of engagement. WRNs who had a planned career approach chose a fast pace to undertake PPD activities within a set time period. For others, their approach towards their careers was unplanned and varied in the speed and pace, yet some had been successful in their careers due to support given to them by employers, which assisted their development. For other WRNs, they only started to build their aspirations as an RN later on in their nursing careers, having already fulfilled other aspirations that were of a more personal nature. These results challenged managers' stereotyping of successful young highflyers moving at a fast pace to achieve their goals. There were many WRNs in this study over forty years old undertaking Masters degrees with the aim of developing their careers.

The perceived and experienced rewards and benefits of PPD ranged from having the qualification that "no one could take away", to having the choice to apply for a job, if they wished. Gaining confidence, self-satisfaction and self-esteem were most commonly cited. Increase in money having gained a higher paid job was welcomed but not always perceived as the main purpose of PPD, but it was viewed that it would certainly help women and their

families. Achieving an academic qualification gave women power and choice, being able to have informed opinions influenced their nursing care, and an ability to act as role models for other RNs and their families and friends.

What was raised in this research was that women had different perceptions, values and experiences as to what the rewards were in comparison to their male partners. For some these were causing conflict and resentment in the home, for some physical and mental abuse (Edwards, 1993). Women's' accounts told that some men did support women's PPD; however, some did not because there was no immediate financial reward of which men valued to be the only reward.

In Theme 3 – The hidden costs of PPD activities and the strategies and techniques that women used to overcome the difficulties. The hidden costs of PPD were found to influence women's PPD journeys and affect the success of their PPD. Some of these costs were predicted, for example, by having to self-fund studies and study outside of paid working hours: this had an impact on women's health, their relationships and their families. Whereas others were not predicted, such as the breakdown of the relationships with partners. Circumstances and/or the hidden costs could prevent women from engaging in PPD, but once reduced, could lead to much more engagement in PPD. This also depended on whether PPD activities were conducted solely within paid work time with funding: many of these activities were not, and encroached on personal, private time.

The strategies and techniques that women used were insightful and were a reflection on women's experiences and how they attempted to manage and cope with the difficulties that threatened their engagement and success in PPD. Some of the examples given in this study demonstrated gender issues, for example when women were found to be studying at night whilst the rest of the family were asleep, were argued to cause the least disruption to the family but had an impact on the quality of work produced. Women's mothers

were found to play an important role in supporting their daughters' PPD, having recognised the value that education could have by empowering their daughters' lives, promoting their careers and leading to a better quality of life.

In Theme 4 – Women's PPD journeys. Women's roles have changed in society the findings demonstrated that many women worked in the professional occupation as a RN. But, returned home to do the "second shift" in the home as homemaker and carer for family members (Hochschild and Machung, 2012). Socio-economic factors of women's lives (culture, race and class) were found to affect women's PPD. Though many employers still offer pension and maternity scheme attractive to women, there are no longer "jobs for life". The economic climate has also led to a change in the way women approach their job roles and nursing careers.

Findings of this study demonstrated the traditional career patterns associated with stages of life are now defunct for many WRN's; as lives continuously change, so do their perceptions towards PPD. Socio-economic factors such as retirement age being unpredictable, responsibilities in the home, and wishing to develop further and undertake more senior roles were found to happen within any part of their lives.

Research findings in this study demonstrate that because of these factors WRNs have now changed their perceptions of their job roles and their planned or un-planned careers were found to alter. That WRN's pace and level of engagement in PPD may fluctuate regardless of their age or number of years qualified. Hence this challenged the stereotypes of a young highflyer, or an experienced WRN preparing for retirement who no longer interested in engaging in PPD. Findings in this study showed experienced WRNs whom having consistently engaged in the minimum PPD activities, increased their pace by studying for further qualifications. In order to prepare themselves for many more years of working as an RN, often being paid at a higher level than in the past.

The emerging PPD model was derived when the construction of the themes started to take place. It became apparent that perceptions, experiences and aspirations play an important part within WRNs engagement in PPD. That in addition to this, the level of engagement can also be affected by circumstances and hidden costs, strategies and techniques can be used to reduce the effect that they have on PPD activities but also to aid future planning. WRN's aspirations can fluctuate and change throughout life. All of these components have an impact on the pace and speed of their PPD journey. Though there are nursing frameworks to offer some guidance, the criticism is that they are descriptive, and are limited in that they offer no advice on how navigate around the difficulties that RNs face (Rafferty et al. 2015). This preliminary model outlines to how these components interact with one another, offering new emerging theory on WRNs PPD but it could also be used as a tool for WRNs to use when looking at their PPD. It could be used as a tool that can aid empowerment and agency for it could act as an aid to planning and managing their PPD, enabling WRNS to navigate around the challenges they may face.

7.2 Summary

This study has raised difficulties that women RNs perceived and experienced when undertaking their PPD journeys. The findings in this study provide a snapshot of what is happening with WRNs and their PPD into today's world. Future research studies exploring women RNs' perceptions and experiences needs to be conducted, to support stakeholders – RNs, line managers, employers, unions, professional bodies, nursing regulatory bodies and governments – to take responsibility in supporting RNs' development by ensuring that PPD is supported in the workplace. It is crucial that RNs have the opportunity to update their knowledge and skills to promote safe practice and a high standard of nursing care. That they can continue developing personally and professionally that will result in RNs meeting the demands of newly developed job roles and aid aspirations of career development. This

study has highlighted a worrying trend that PPD is becoming something that is only accessed by RNs who are able to find time to study outside of paid working hours. In addition, many are not financially supported by the employer, so have to self-fund their PPD activities. Circumstances and the hidden costs of PPD demonstrate the barriers that WRNs already have to face in their PPD journey. Strategies and techniques raised in this study demonstrate that women can overcome barriers, but support is imperative for women RNs to be successful in their PPD journeys. Stakeholders need to ensure that opportunities are provided to everyone and prevent marginalisation of WRNs regardless of personal support and financial capabilities for without this, they risk losing WRNs because they do not have the evidence required for re-registration/validation or they no longer wish to work in nursing.

7.3 Limitations

This study aimed to research women's experiences and perceptions of PPD. It aimed to compare women from two countries, it was not designed as a cross cultural comparative study, even though as preparation for the study design through research was carried out to explore the cultural differences between each country (see Appendix D). The DDS did collect some information on women's race, it was unsuccessful in establishing class. In terms of race, as previously discussed women interviewed were representative of some but not all of the population[36]. In addition to this it

[36] In the UK sample, the majority of the participants recruited were from the English UK university site. This was in a predominantly white British area; all fifteen participants described themselves as white British. The 2011 England and Wales census recorded white British as 86%. In the SA sample I recruited black African (nine), coloured (twelve), white SA (two) and Indian (one), a total of 24 SA women. The SA 2011 census (Statssa.gov.za) recorded black African as 76.4%, coloured as 8.9 % and white as 9.1%. The sample from SA therefore had some representation of women in their country, but not all races. There were no participants from the following ethic groups. Terms used in SA and the UK: Asian, other SA ethic groups, white, other, Pakistani, mixed race, Bangladeshi, white Irish, black Caribbean, black African (UK), black other (UK).

could be argued that the limitations were that only two white SA women were interviewed, and only white women were interviewed in the UK. No participants declared a disability, myself the researcher, declared a disability.

A study with a larger number of participants across the regions and provinces of SA and the UK could be more representative of women from differing race, class and disability.

None of the women from the UK had experience of working for private employers, hence no comparison could be undertaken.

Men had not been involved in this study therefore men have not been represented. The emerging PPD model has been designed using a feminist approach.

The findings asserted that many WRNs viewed managers not supporting PPD. This research did not question to what gender managers were. The research design did not aim to interview managers' perceptions and experiences to how they supported RNs PPD, though a few participants were in management roles.

This study did not aim to measure the amount of monies women spent on paying fees to undertake PPD activities, nor the additional expenses that occurred so that women, could have some time to study without disruption and successfully complete their studies. It could be suggested that if WRNs started to record this, and further research was carried out on the monies women spent on PPD it would help raise employers' awareness of the costs (some of which are hidden) that can occur when undertaking PPD activities, and re-consider their approach of how to support RNs PPD.

7.4 Recommendations

This study has raised the difficulties that WRNs perceive and experience when undertaking their PPD journey. Data collected using CGT methods and

a feminist approach has provided a detailed exploration of what is happening with WRNs and their PPD into today's world. These recommendations have implications for policy, education, practice**,** and research, in both countries (unless stated otherwise). Table 9 below outlines the recommendations. Individual RNs have the right to access PPD, they need to have power and control in managing the evidence that is required to be able to re-register.

Issue	**Recommendations**
RNs having difficulty in accessing training and education. All nursing stakeholders need to take responsibility in supporting WRNs development. Risk of RNs not having enough evidence to enable re- registration may result in no re-registration and RNs unable to work.	Introduce into **practice and education policies:** Employers to promote the practice of RNs using of portfolios, to aid collection and assessment of evidence required for re-registration. Action planning to be a key activity within RNs portfolios. Actions plans devised by RNs on an individual basis can be raised with line managers as part of the appraisal process or in other conversations/ meetings with line managers. Reducing the risk of RNs not being able to re-register. Introduce the **practice** of using the emerging PPD

	model as a tool for RNs to use that could aid RNs development. Further **research** on the ways in which RNs are using portfolios to aid their development, compile evidence of PPD, undertake activities such as action planning and use for re- registration.
NHS and other healthcare employers must provide enough **training and education that is** required for RNs to re-register and develop themselves personally and professionally RNs need to be confident in line managers and employers' actions of supporting their PPD.	**Policy and practice** Policies and processes for undertaking and applying for support for PPD activities need to be reviewed. Details of named staff member/s who offer to be available and willing to offer supportive guidance. For RNs to contact and seek clarity on the policy and processes. Policy needs be updated to record, monitor and write action plans to ensure that RNs are getting support for their PPD activities.

Lack of RNs' satisfaction of the support from the line managers and/or employers,	Managers must act upon and record the actions that they have taken to support RN's development. With regards to funding, paid time, applications for bonuses and appraisal. These actions must be recorded so that employers can audit the workplace and the line manager's approach to supporting staff. Employer's must publish details and numbers of staff who had received support for PPD activities for staff to see, and to go onto the employer database so that these can be reviewed by the employing organisations' chief executive. Yearly plans need to include targets for PPD activities. Line managers can review policies and create action plans to encourage more PPD activity. This will impact on recruitment and retention of staff.

	Employers to review policies that support staff development. For SA the review of the application criteria reducing the number of years that the RN has worked, making jobs at senior levels more accessible to RNs whom hold the appropriate qualifications Committees/panels within the employing organisation that make decisions to who receives support, could include RNs who are not within senior roles who act as observers and feedback on fair **practice**. Reports providing general information of the outcomes, need to be accessible to all staff.
Revision of policies on education, training, funding and support for PPD activities to be accessible (on the website and/or hard copies), Written in transparent and easy to understand basic	

English language. A complaints system needs to also be made available for RNs to use if necessary.	
Staffing policies not accommodating time for RNs to undertake PPD activities	Government and nursing stakeholders need to revise **staffing policies** urgently so that time is allocated for RNs to undertake PPD activities on within and outside of the work place
SA NHS	**Policy** on pay scales to be reviewed, and the number of years' experience required for pay scales to be reviewed and altered. The introduction of academic qualifications needs to be introduced into these pay scales
Line managers not supporting RNs PPD, line managers not having the knowledge and skills to explore and suggest ways to overcome barriers and promote planning and action	**Education** and training courses for line managers to be reviewed. **Policy** on training and education for managers to be reviewed and updated. This would include positive ways to encourage RNs PPD, strategies and techniques used, and education on

plan of PPD activities.	the emerging PPD model with case studies, could increase line managers knowledge and influence the practice of encouraging and supporting PPD. Cultural issues within the employing organisation would also need to be raised within this training.
Using knowledge of the emerging PPD model and case studies to aid PPD and educate RNs and line managers	**Education** Employers and nursing stakeholders could introduce the PPD model to RNs, for individual use and if RNs wish to use when discussing development with line managers
SA NHS accessibility and use of CPD days	**Policy** on the use of CPD days within every NHS employer needs to be aligned with national NHS policy. Regular **practice** of yearly reporting by NHS employers needs to be carried out to establish how many RNs use CPD days. Responsibility will be taken by employers to identify which work areas that do not allow CPD days. Audit would also

	need to be undertaken by staff to establish any other barriers to using CPD days. **Research** needs to be undertaken to establish what CPD days and being used for and the problems occurred.
Not enough funding available (public, private employers, unions or charities) to support RNs' PPD. Nursing stakeholders within SA and the UK need to work together with nursing stakeholders to continue to look at ways on how to create funding opportunities for RNs PPD.	Resources need to be sought to aid funding of RNs PPD. **Policies** revised to include active working towards devising funding opportunities for RNs.
Actions to prevent abuse of RN's and promote recruitment and retention of highly qualified RNs	**Policy** to incorporate employee contracts for RNs undergoing further training with academic qualifications, with specific statements on completion of the academic qualifications that results in (1) an automatic pay rise or/and

	(2) a financial reward or/and (3) commitment to a permanent contract. Nursing unions to create examples of these contracts, for employers and RNs to use as examples of good employment practice
Evolving knowledge and research of RNs experiences of PPD	Further **research** to capture women RNs from all backgrounds including disability would add to the findings of this study Further research on men RNs may also add knowledge on PPD
	Further **Research** on informal PPD activities being conducted by RNs working for both public and private employers. The results will initiate discussions with employers and nursing stakeholders on the review of staffing and **education policies,** and workplace culture of learning and development of staff.

Table 9 Recommendations

Future **research** studies exploring WRNs' perceptions and experiences need to be continued, to ensure that all stakeholders take responsibility in supporting WRNs' development. This is imperative, as the registration nursing bodies across the world are now introducing the requirement for WRNs to provide evidence of PPD so they can re-register. Evidence from this **research** makes recommendations that may promote changes in **practice, policy** and **education**.

Access to training and education that will contribute as evidence for RNs portfolios and re-validation/ re-registration

The data had been collected from WRNs when **UK W**RNs were expected to have portfolios to demonstrate evidence of PPD. Since collecting this data, the NMC re-registration process has changed. RNs are now required to provide evidence in the form of reflective statements, the NMC encourage portfolios to be kept (NMC 2016).

The UK NHS encourages employees to use a portfolio and provides examples of portfolios and e-portfolios for staff to use (NHS, 2018). At the time of collecting data in **SA**, SANC had only just introduced re-registration that only required payment. In 2018, they announced that, in the future, RNs would have to hold a portfolio of evidence. To re-register, RNs would have to have evidence of having acquired CPD points and hold a portfolio. Those CPD points would be *'accrued by activities and events that are offered by service providers who have been recognised by SANC'* (SANC 2018). It is recommended that further **Research** needs to take place to establish if RNs experience the use of portfolios as a way of assisting them in compiling evidence that can be used to for re-registration/re-validation.

In light of the findings, whereby due to the lack of support from employers, women RNs who want and need PPD are having to resort to self-funding and

using their own personal time to undertake PPD. This may leave some women who are not in the position to use their own personal resources for PPD, vulnerable and at risk of not acquiring enough evidence to re-register. Recommendations are that the NHS and other healthcare employers must provide enough **training and education** required for RNs to re-register.

RNs have the right to access PPD activities (ICN, 2001; SANC, 2017). If portfolios are expected to be kept, that they are used to help RNs monitor what PPD they have achieved and to if they have compiled enough evidence that can be used to support re-registration. It would be an essential recommendation for action planning to be a key activity within these portfolios. The impact being employer **policies** give RNs the right to present these action plans to their managers, alerting managers to if they need to place their PPD as priority. That managers must act upon and record the actions that they have taken to support the RN. This may reduce the risk of not having enough evidence to re-register.

Staffing policies and time for RNs to undertake PPD

Shortage of staff was given as common reason to why RNs could not have time to undertake PPD activities within paid working hours. It is recommended that Government and nursing stakeholders need to **revise staffing policies** urgently, for policies that support the nurse to patient ratios are written to primarily to protect patients and ensure that they receive a high standard of nursing care (RCN, 2020; Welsh Government, 2016). However, they are not written in mind of the PPD activities that RNs need to undertake within paid working hours that will aid them to be up to date and safe in their practice of which are RNs professional rights. The impact of revised staffing policies that support WRNs PPD will enhance PPD for all RNs.

The participants in this study represented some, women of ethnicity, race, class that had lived and worked in rural, suburban and city areas of SA and the UK. Further **research** with funding attached, that would capture women from all backgrounds including disability (Appendix D) and their perceptions and experiences would add to the unique findings from this study. **Education** is empowering for women, and therefore it is essential to continue researching issues that are related to gender.

SA PSD NHS Pay Frameworks and essential job criteria

The **SA** OSD (NHS) pay framework **policy** introduced a number of initiatives such as the specialist nursing grade and the general nursing pay scale. The specialist nurse is offered financial reward to those who have expertise and hold a postgraduate diploma. This demonstrates that experience and academic qualifications are recognised as essential for this grade. However, findings in this study revealed **SA** women's frustration in having the ability and the qualifications (often Masters') to do a job, but not being able to apply for jobs due to not having the experience stated in job descriptions (these ranged from 1-15 years). At the same time in which the OSD commenced it was also the general pay scale for nurses that dictated by the number of years' experience (0-5 years, 10 and 30 years). Hence some job descriptions and this pay scale framework indicates that that experience is valued highly, however the criticism is experience does not indicate if you are competent and have the knowledge and skills, current policy offers no reward to those who have achieved these qualifications.

Recommendations are **SA HR policies** such as job specifications stating 10 -15 years' experience need to urgently be reviewed and the number of years reduced significantly, otherwise the impact will be that employers may find it difficult to retain highly qualified RNs (who are being employed on a lesser grade). Urgent action needs to be taken to review the pay scales and the

criteria on the number of years' experience required for jobs and within pay scales. For RNs employed in the specialist nurse grade, additional increments need to be added for those who hold masters' qualifications. The impact will result in policies that support RNs PPD.

Informal PPD activities

Informal PPD activities are essential to RNs' development. Yet, they seem to be disappearing from the work area, often with the suggestion that this was due to short staffing. It is recommended that further **research** is required to establish if this is commonplace at all public and private healthcare organisations, and what attempts are being made to overcome short staffing issues that are argued to be the main cause in the decline of informal PPD activities. Questioning to how employers can make these informal PPD activities more visible and undertaken on a daily basis within the workplace. This is essential for the PPD of RNs who have the right for continuing development that will be of benefit to the service provision. Some women have no personal or private time due to commitments and responsibilities in the home and are being discriminated against by employers. For them PPD activities can only be conducted during paid working hours. This review is urgently needed at present it limits access to PPD to those who can, or who are willing to commit personal time to professional development. **Research** findings my influence a change in **policies** and influence **practice** of informal PPD activities in the workplace.

Training managers to support RNs PPD

There were considerable negative statements about managers not supporting PPD. The lack of funding, paid time, and short staffing were found to be hindering managers' ability to support their RNs PPD. However the

findings suggest: that some managers do not have the knowledge or insight on PPD activities that could be conducted in the workplace that aid development, they do not have the knowledge or skills to support RNs in writing applications, offer career development advice, use of a nursing portfolio and nursing career frameworks, where and how to apply for funding, or how to support RNs studying courses at university. That appraisals are not used positively to support, encourage or to facilitate problem solving solutions to supporting PPD. The Triple Impact Report (APPG, 2016) that is also supported by the ICN, argues that we must train and educate nursing managers to lead and encourage PPD for RNs. The RCN (2020) report on Gender and Nursing as a profession argue that nursing leaders must be at the forefront of change to improve nursing and PPD. It is recommended that training courses need to be created to **educate** and raise manager's insight, knowledge and skills. It is recommended that the emerging PPD model could be introduced to RNs for it could be the ideal tool encouraging an increased awareness and insight to the complexities of PPD for women. Hence enabling managers to be able to offer constructive advice and guidance. That could influence the **practice** of encouraging and supporting PPD for RNs. However, this preliminary PPD Model could not be used as part of the appraisal process for RNs, for they may not wish to divulge to their line managers personal information or professional aspirations. Individual RNs may differ to argue this, for their line manager could be a positive role model, trustworthy and wish to promote all of their RN's PPD.

New findings revealed many hidden costs that had not been identified in previous studies on RNs' perceptions and experiences of PPD. **Education** for managers needs to also include the knowledge gained from this study on the strategies and techniques that women used to access and engage in PPD activities. For it is these strategies and techniques that are used by women to counterbalance the personal challenges that women face when

undertaking PPD. The impact being that managers could become more supportive towards their RNs PPD activities.

If portfolios are continued to be used as a tool to aid women's PPD. The emerging PPD Model could be placed as one of the standard resources within the content of the portfolio. Examples of women's stories of PPD could be used to explain how the tool could enhance self-awareness, aid planning for the future, and map out alongside career frameworks any aspirations or goals women wish to achieve in the future. Hence the PPD Model being used as a tool could be used to **educate** RNs and influence a change in **practice**.

Revision of policies to ensure they are transparent, easy to understand and accessible to all RNs

The findings indicate that RNs are not always able to access or interpret employer's **policies** or procedures that are linked with PPD: funding, time, applications for bonuses and appraisal. This has caused RNs to perceive these procedures as unfair, with "hidden rules" and allowing managers and employers to change these to suit their own needs. To improve women's perceptions of employers, the government and healthcare employers must revise these **policies** and procedures to ensure that RNs can access these policies in order to aid transparency and minimalize the perceived unfairness.

It is recommended the **policies** on support given for RNs PPD needs to be much more transparent so that RNs perception on the **practice** of gaining support is viewed as fair. The criteria that employers use to indicate RNs to be eligible to apply for support for PPD. Needs to include taking action to reduce the number of years the RN has to work for the employer, before they can apply for support. It is strongly recommended that results on how many RNs received support from their employers should be shared with employees

to demonstrate decision making on the allocation of support given to applicants.

Transparent decision making and reporting in relation to policies and schemes that provide support for RNs PPD

It is recommended that the employer should as part of their **policy** provide a named contact who has had training (the policy stating what this will involve), and will be able to assist and offer advice RNs on the criteria and standard of application (hence RNs are able to access support from knowledgeable persons). Committees or Panels that make decisions, on which applications are successful. Should as part of their operational standards, invite two RNs who are employed in the organisation to observe and offer feedback to the Committee/Panel. Feedback should relate to if they agree that the decisions made have been fair and based on the policies and criteria. The impact will be RNs, line managers, and Committee/Panel members will have a better understanding of the policies, and believing that these systems are fair, understanding the criteria and gaining credible advice and support.

Accessibility of **SA** CPD days and transparent reporting

The management of accessibility CPD days ("exam days") for women in **SA** needs to be tightened up considerably for the findings demonstrate that the government's initiative that aimed to support PPD in the NHS is being manipulated and re-shaped by employers and managers. That women are being treated unfairly by not having access to these even though they meet the criteria by undertaking PPD activities. The government needs to take action and assert that this **policy** is implemented in **practice**. They need to insist that every employer holds a database to record CPD days taken by staff and for what PPD activities they were undertaking. On a yearly basis

reports are published on their website include: the number of staff who have, and have not accessed these CPD days, the areas that staff work and the profession, the number of rejections and why, and most importantly the number of days taken and the type of PPD activity. Audits should be conducted by each SA Province, and action plans based on how to increase the numbers of RNs accessing this scheme needs to be set on a yearly basis. A similar design could be used for the SA NHS bonus system for this **policy** is also designed to support PPD.

Creation of more policies and support schemes aimed to support RNs PPD

To support the Triple Impact Report (APPG, 2016) healthcare stakeholders, including universities need to re-visit and take more responsibility in setting up more **policies** that support schemes to provide opportunities for women RNs to receive funding that will support their academic studies. The findings show that women can no longer rely on employers to support courses that will aid their PPD and support career development. For some women they will never have the finances to be able to study a course at university hence their careers could be stunted, and deny women the opportunity of social mobility. This may become increasingly more common as bursaries and grants for student nurse training are withdrawn, hence qualified RNs may enter the profession with financial debt and may not be able to pay for PPD activities. The impact would be that supportive policies to support funding would benefit WRNs who no longer can gain this support from their employers.

Employers offer employees financial reward for completing named training and awards acting to support retention of RNs – these are stated within RNs work contracts

Results of these findings recommend that to prevent abuse of women (and risk attrition of highly qualified staff) (RCN, 2020). It is recommended employers as part of their retention **policy** provide working contracts that include guaranteed payment on completion of training/qualifications. WRNs automatically receive a wage increase in line with the national pay scale associated with the knowledge and skills required to perform in their job. That nursing unions should place examples of these contracts for employers to use as a basis for contracts that rely on women undertaking PPD that ultimately benefits the service provision and campaigning for fair pay and treatment for WRNs who are expected to work at higher levels, without receiving the correct wage. For RNs see their jobs as a career and have earned the right to be paid accordingly.

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Appendix A **Background section providing information on the comparisons between the UK and SA nursing**

This background section has three sections to it: comparisons between UK and SA nursing, history of SA nursing and a personal perspective of UK nursing from the 1980's.

1st Section Comparisons between the UK and SA Nursing

This section covers information on: qualifications and entry into nurse training, standards of nursing and healthcare education delivered in universities and colleges, registration of qualifications on the nursing regulatory body, nursing unions, post registration education and training courses or training programmes that are approved and regulated by the nursing regulatory bodies, registration of the RN on the nursing regulatory body, adhering to the regulatory nursing body's code of practice (including codes of conduct and ethics), registration of RNs by the regulatory nursing body and the requirements to demonstrate evidence of PPD. Finishing with information on the pay frameworks that incorporate knowledge and skills used within RNs job roles. In 2019 there were 661,000 registered nurses in the UK, (Statista.com). In 2018 there were 57,725, 606 registered nurses in SA (SANC, 2019).

RNs working for the NHS

The UK and SA share the commonality that they both have a National Health Service (NHS) that is run by the government. This is a hierarchical structure with management and HR departments that controls the organisation (NHS 2016; Department of Health, 2017). That the benefits of working for the NHS include for both countries; a contract of working conditions, set holiday entitlement, set working hours, entitlements of pay and overtime pay, paid sick leave and government pension.

Qualifications and entry into nurse training

The UK and SA both have established standards for nursing education programmes for RNs that are approved and governed by nursing regulatory bodies; Nursing and Midwifery Council (NMC) and South African Nursing Council (SANC) who register these training providers. Entry qualifications and experience to enter nurse training are standardised for the level of nurse training that is being undertaken. They can be academic qualifications (often studied at school or college) or/and vocational qualifications (In SA, the school leaving Matrix certificate is required). Some women may not have

entered nursing at the age of 18 years old, i.e. straight from school or college. Some may have experienced teenage pregnancy, or be told by their family members that as a woman, they didn't need education to get a job. Others will have not been able to afford education, and had to undertake a range of training via the workplace and educational study be able to enter nurse training.

In the UK RN training is undertaken within the university setting at degree level, taking 3 or 4 years to complete. Additionally, the RN is also referred as by the historic name taken from the army; staff nurse. In SA nurse training is undertaken within universities and some colleges, taking 3 or 4 years completing a degree or a diploma and they are called a professional nurse. For the purpose of this study the term Registered Nurse (RN) has been used.

Some SA nurse training colleges run by the public or private sector still run a degree professional (registered) nurse programme (Mqolozana.T., 2008).

This is becoming less so because of changes in legislation and a push to run training programmes within universities (Rispel and Armstrong, 2015; Oxford, 2016) . The RN training in the UK is based on focusing on only one specialty: general, mental health, or learning disability. Midwifery is undertaken in a separate 3 or 4 year programme. Whereas SA offers a professional nurse qualification in one speciality or an integrated training programme (a degree or diploma) that incorporates training and assessment that equips them to work in specialist areas: general, psychiatric, community and midwifery, which can only be offered by public run universities or colleges (Rispel and Armstrong, 2015). Hence in this study R's may make reference to the experiences and perceptions in relation to their role both as a nurse and a midwife.

The UK has discontinued diploma nurse qualifications. The majority of SA (public or private) nursing colleges tend to run nursing programmes that are degree or lower level such as the diploma in nursing - a staff nurse qualification, enrolled nurse (EN) (2 year course), bridging course for EN's and enrolled nursing auxiliary (1 year course) qualifications (all are recorded by SANC). At the time of writing a few colleges still run diploma courses.

In the past both countries used the same system, that being, once a student nurse had met the standards required and deemed to be fit to practice, that they could apply to be registered on the nursing regulatory body, which allowed them to practice and work as a RN.

In SA as part of a governmental strategy it stipulates that to support recruitment and retention of staff in the NHS (preventing newly qualified going to work straight away for private employers) and to allow RN's to gain confidence in their professional practice, they have to work for one year undertaking "community service". Only once they have completed this year,

and have relevant evidence of doing so, they can register with their regulatory professional body (Health Systems Trust, 2004; SANC, 2016a). When undertaking this research it was evident that there was a lot of discontent with this new system. In that, the newly graduated RNs were paid a lower wage than what they would have received in the past for their first year after registration. Some were not able to find placements, and some had to move from their current residential area to rural areas to undertake community service, and there was no evidence that this aided RNs PPD (Health Systems Trust, 2004). Financial implications of this new system on individual women RNs and their PPD had not been considered, so no current research had been published.

On one hand the positives of the EN training was lower entry requirements, which allowed women to be able to train as a nurse. The negatives were that some women were discriminated against by only being offered EN training (an example of this in the UK is migration black Caribbean women in 1950's and 1960's) (BBC, 2018). Those holding EN qualifications may have had their career opportunities limited by not being able to apply for higher jobs.

Nurse training has moved to having an academic accreditation and a shift has been made to move nursing education into higher education. Bringing the recognition of nursing as a profession, and with degree status. In SA however, there is still nurse training being undertaken in nursing schools attached to hospitals in both the public and private sector[37].

At the time of commencing this research, the UK nursing qualifications below RN status that could been used to support applications to enter the RN nurse training programme were; the Enrolled Nurse qualification (EN) (this training was discontinued in the early 1990's, bridging courses for EN's to convert to RNs were offered, but these have also been discontinued). Health Care Assistant (HCA) or auxiliary nurse role that could have led to undertaking National Vocational Qualifications (NVQ's) at level 2 and 3 (not registered by the NMC). However it also needs to be recognised that in the future entry into nurse training may change, with the introduction of the nursing associates, assistant practitioners and the nursing apprenticeship degree (Consultation.hee.nhs.uk, 2017).

[37] In SA, it faces many challenges that are unique to its country in being that many people live in poverty and unemployment rates are high, which can result in corruption. SA still faces challenges with bogus nurse training schools claiming to be registered training centres, and people claiming to be nurses (Comings, 2005).

Standards of nursing and healthcare education delivered in universities and colleges

SA and the UK both have public universities that run nursing and healthcare courses. The university academic and teaching standards, are governed in different ways (USAF, 2018; Brand South Africa, 2018; Quality assurance agency for higher education, 2018). Nursing academics Rispel and Bruce, (2015) argue that poor management and mixed messages has caused a disparity of the standards in nursing education (Oxford, 2016). In SA, both public and private colleges run nurse training programmes, including the professional nurse qualification. Some private health care organisations employ students on a contract, with their training carried out within a training school that is based on the hospital's site (this model was previously used in nursing education). SA still faces challenges with bogus nurse training schools claiming to be registered training centres, and people claiming to be nurses (Comings, 2005). Most SA and UK universities have degree awarding powers, but other organisations such as colleges do not have these, are then affiliated to a university so that their course/qualification can include an academic accreditation.

Hence qualifications to enter degree nurse training is far higher, than those who undertook nurse training in the past, which did not have academic accreditation or for those who entered and undertook qualifications of a lower level.

Registration of qualifications by the nursing regulatory body

Both of the regulatory bodies decide to which post registration qualifications need to be recorded on the register. In both countries it is noted that not all post-qualificatory qualifications are placed onto the register (in general these do not include Masters or PhD qualifications).

What differs between the two countries is that on commencing this study is:

> Indemnity insurance is a requirement of any RN in the UK who wishes to be registered and undertake the revalidation process (NMC, 2015b, 2017b).

Some employers such as the NHS offer this as part of their contract with employees, whereas others do not, meaning that membership of a union that offers indemnity is essential. The SANC website makes no reference of indemnity insurance or the requirement to have this, and Rispel and Armstrong (2015) confirm that there is no requirement.

Nursing unions

Both the UK and SA RNs have the option to join a nursing union. In the UK unions that RN's belong to are; the RCN, Unison, and Unite. In SA the unions that RN's belong to are DENOSA, NEHAWU, FUNDISA and ANSA (see the glossary for more information). The unions that are the most representative of RN's are invited for consultations by regulatory body and government review boards are: the SA's DENOSA and the UK's RCN. Up until recently both SA and the UK were members of the International Council of Nurses (ICN) (it needs to be noted that the RCN discontinued membership with the ICN in 2013). This a federation of national nurses association representing nurses worldwide by raising and setting standards for global nursing.

Post registration education and training courses or training programmes that are approved and regulated by the nursing regulatory bodies.

In both countries, post registration nurse qualifications can be undertaken at any academic level or with no academic credits. These courses can be accessed at universities in both countries. In SA, public and private colleges also offer some specialist nursing courses. The regulatory body makes a decision to which post registration courses have to be recorded on their register, with the rational being that they are safeguarding the health and safety of the public. For example, in the UK recordable qualifications are: practice teacher, nurse prescribing and specialist community practitioner.

In SA recorded qualifications: nurse educator and the post graduate diploma: nurse specialists (with a variety of named specialities), and the advance nurse practitioner in a number of specialities. The nursing administrator post basic course is a popular course because to access some jobs at a higher grade than the basic nursing grade, this course is often deemed as an essential requirement on job descriptions.

Other qualifications at higher academic levels such as Masters or PhD level are not necessarily recorded by the regulatory bodies. For example, in the UK, the title Advance Practice Nurse (AP) is not regulated by the NMC, therefore anyone can call themselves an AP (Baileff, 2015). However, the RCN state that Advanced Nurse Practitioners (ANP) are educated at masters level. They set standards for collaborating higher education institutions to put into to their programmes, that will ensure that ANP educational programmes will receive RCN accreditation (RCN, 2015a). Other nursing speciality courses may also not be recorded by the regulatory bodies. Instead the education providers, universities or colleges design and regulate their own programmes referring to core nursing documents (regulatory body, governmental, nursing specialist organisations). In the UK the mentorship qualification is highly sought after because this qualification can be used to access jobs at a higher level than the basic nursing grade band 5; mentorship is often deemed as an essential requirement on job descriptions

at band 6. Nurses who undertake the non-medical independent nurse prescribing course can apply for this to go onto on the NMC register, this is can be found on senior nurse job descriptions as essential criteria.

Registration of the RN on the nursing regulatory body's register

In the majority of countries around the world, state RNs by law must be registered to practice on their country's nursing regulatory body's register; legislation that supports this is the UK's Nurses, Midwifery and Health Visitor Act (1997) and the SA's Nurses Act (2005). Without registration (this includes payment), RN's will not be able to gain employment working as a nursing professional, as employers have to check that RNs are on the register (SANC, 2016b; NMC, 2017a). At the time of carrying out this research, in SA this stipulation of all RN's, having to have paid their fees by a set date, in order that they would be placed on the register, was still being put into place by SANC (2017a).

Adhering to the regulatory nursing bodies codes of practice (including conduct and ethics)

All nurses registered on the regulatory body's register have to adhere to their regulatory body's Code of Conduct or Code of Ethics, which states that they are required to remain up to date in their knowledge, skills and their practice (Canadian Nurses Association, 2008; Nursing Council of New Zealand, 2012; South African Nursing Council (SANC), 2013; American Nurses Association, 2015; NMC, 2015b). This sets a professional standard for all nurses to adhere to.

It needs to be noted that SA has a Code of Ethics, however they also refer equally to their Nurses Service Pledge (SANC 2018). This pledge is often recited at nursing meetings, ceremonies and conferences to reaffirm their commitment to nursing standards. White, Phakoe and Rispel (2015) argue that nurses use this pledge to reflect on their practice, knowledge, skills and CPD. Hence in this study, the SA Nurses Pledge and the Code of Ethics are viewed to be equivalent to the UK NMC's Code of Conduct, (SANC, 2013, 2018; NMC, 2015c).

Registration of RNs by the regulatory nursing body and the requirements to demonstrate evidence of PPD

RNs in both SA and the UK are required by law to be registered by their nursing regulatory body to be able to practice legally within their country. RNs need to pay a yearly fee, provide up to date personal information, and provide evidence of recordable qualifications (recordable qualifications are set by the regulatory body) and practice according to the regulations. SA RNs are provided with an Annual Practicing Certificate to give to employer

whereas UK RNs are given a personal identifiable number (PIN) that the employer uses to access their registration.

In SA it is more common to have self-employed RN's, often working at private clinics. These RN's also have to be registered on the local governments' register as competent to practice. They have to present evidence that they have undertaken and updated themselves by engaging in the listed trainings that have been set by the government, having to self-fund these trainings. These trainings are similar to the SA in-service training days.

At the time of collecting data for this study SANC did not request evidence that could demonstrate through the RN's PPD activities that they have maintained and updated their practice. The UK's NMC required RN's to have a portfolio of evidence, to demonstrate the number of hours practiced and the number of hours undertaken carrying out CPD activity.

Since collecting the data SANC have announced that they will be introducing a CPD point system as part of their re-registration (SANC, 2018a). The NMC have introduced a re-validation system, that requires evidence of reflections in practice relating to the NMC code of conduct (NMC, 2015a, 2015b, 2018).

Pay Frameworks for RNs

In UK they have the Agenda for Change, Knowledge and Skills Framework (KSF) introduced in 2004, in SA the Occupation Specific Dispensation (OSD) that was introduced in 2007 and is not dissimilar to the KSF framework (Department of Health, 2004; Fouché 2007; Information, 2007; Public Health and Social Development Bargaining Council, 2007; www.nhsemployers.org, 2016). These frameworks are designed in a hierarchical graded order, in the UK the roles for RN's are placed within set "bands" from starting grades 5 to senior levels grade 8 and 9. The UK system differs from SA in that also has two gateways in each band. The foundation gateway requires demonstration of the set skills and competence, the upper gateway requires demonstration of being fully competent of the criteria set in the knowledge and skills framework. Hence the RN's needs to demonstrate their PPD at their appraisal meeting. Line managers can, if they deem that the RN is not performing to the standard of competence required in the job description/knowledge and skills criteria, refuse to allow the employee to progress to move onto the next incremental pay scale (RCN, 2017a). Hence the trusting relationships between the line manager and the employee may not be as harmonious as it could be.

In SA they also have set grades and banding with a minimum pay scale to a maximum pay scale for that band. The SA system differs in that it has a number of different streams, which are separated into grades, with salary notches that can vary from 5 to 10 notches. There are three nursing streams called: general nursing stream, speciality nurse / primary health care, and

nursing lecturing stream. Additional points on this incremental scale can also be offered (Department of public service and administration, Western Cape, 2014; www.nhsemployers.org, 2016; RCN, 2017b).

The SA NHS pay scheme differs from the UK NHS in that it pays RNs who work in designated specialities more money, so that in other specialities this was designed to attract RNs to work in these areas that experienced shortages (Health careers, National Health Service, no date; Department of Public Service and Administration, 2009; Ditlopo *et al*. 2013; Department of public service and administration, Western Cape, 2014; NHS employers, National Health Service, 2016; RCN, 2017d; www.payscale.com, 2017).

To earn more money SA RNs can apply for specialist job roles that have a different pay system, such as the nurse administrator role and those employed in the speciality nurse and primary health care stream are on much higher pay scales than the other two (nursing academics employed within universities also find that their wages are less than those working as a speciality nurse and primary health care). Ditlopo *et al*. (2013) argued that this targeting of specific specialities, has resulted in ignoring other specialities such as general medicine areas that do not gain as good pay. This has resulted in RN's being less willing to work within those speciality areas, or to undertake PPD to develop in these areas. The difference in payment according to speciality was agreed when the OSD was being formed (some of these decisions are still being challenged today).

Other key differences between the UK and SA system is that the SA nursing banding is that is has three distinct bandings, that these are in relation to the years practiced as an RN, and not the PPD activities that they have engaged in or the academic qualifications that they have gained. This results in RNs not being able to apply for higher graded jobs (higher wage), unless they have the stated number of years' experience, despite to if they meet all of the job description essential and desirable requirements. Thus, RN's in SA have less freedom to apply for jobs and move quickly up the career ladder (unless they chose a speciality earmarked for higher pay). In the UK, job descriptions with managerial responsibilities generally range up to five years' experience, in SA this would be 10 to 15 years of experience.

(3) Changes in nursing education that may have had an effect RN's perceptions and experiences of PPD

Worldwide, nursing education has changed in many ways, all of which may have an impact on RN's experiences and perceptions on PPD. The changes made to pre and post registration education and the impact that it may have had on RN's PPD. The education of RN's being moved from hospitals to universities and also the introduction of pay frameworks designed to link knowledge and skills, appraisals and personal development planning and

support the concept that all healthcare professionals need to undertake lifelong learning, CPD and PPD.

To be recognised as professionals the nursing education has gradually moved away from schools of nursing based on the hospital site, whereby they would receive a working contract and a small wage to be based at colleges and universities, so that it becomes an all degree profession. This has resulted in; potential nursing students having to have a higher level of qualifications to enter training than in previous nurse training, nurses who qualified prior to these changes may have carried out nurse training that had no academic accreditation.

Thus for potential nursing students it may take them much longer to acquire entry qualifications to be able to enter nurse training, should they not have achieved them at school or college. In the meantime, they may be undertaking work in caring for others, which would support their application. Women enter nurse training at all ages, for some, this is because they have not been able to afford the financial costs to undertake study, and therefore undertake vocational qualifications that are completed whilst working. In SA, they do not offer many vocational qualifications, relying more so on the school leaving Matrix certificate (that is not always achieved by school leavers), and many have to pay for studies (often privately) to gain these qualifications. Whereas in the UK for those without having achieved the qualifications and grades at school or college, they also have the option of undertaking vocational qualifications that are designed to aid entry into nurse training; NVQ level 2 and 3, nursing apprenticeship, foundation degrees (Health Education England, 2015; Consultation.hee.nhs.uk, 2017). Hence post registration nurses may have started to form and reflect on their perceptions and experiences of PPD, leading up to, during and after gaining their nurse qualification.

Those undertaking nurse training will have to have pay for their nurse training. There are constant changes being made by both SA and UK governments. What they do is demonstrate that government bursaries and grants are becoming less accessible for students, so student nurses have to rely on student loans (Wildschut and Mqolozana, 2008; Royal College of Nursing, 2013b; Womens Resource Centre, 2013; All-party Parlimentary Group on Global Health (APPG), 2016a; The British Broadcasting Corporation (BBC), 2016a, 2016b; Johnston 2017; Westerncape Government 2018). The UK's National Union of Students (NUS) highlight that many students having completed their studies at university have loans to pay back (NUS, 2015, 2016). In SA, the Department of Women, (2015) Report argued that women in SA have less access than men to apply for bank loans. Bringing us to conclude that by owing money to others, can prevent newly graduated students from engaging in further PPD or formal courses, as they are concerned about the money that they already owe. Whereas in the past

recently qualified nurses did not have any loans to pay back, but today this is common for newly qualified nurses.

The 2-tier system of RN is the first level nurse, and the Enrolled Nurse (EN) as the second level nurse, was discontinued by the UK in the 1990's, and is now being discontinued in SA (SANC, 2018). Bridging courses can be undertaken for EN's to become RN's, however finances to support study on this course would need to be found by the individual RN. Once again these nurses may have not undertaken study at an academic level.

Moving nursing to an all degree profession, means that those who undertook traditional nurse training or undertook the diploma nurse training (this is no longer offered in the UK but is in SA), may need to undertake further studies to gain their degree. For others the benchmark has moved higher and they have needed to gain a master's degree.

Second Section – The history of South African nursing

Addressing the complexity of SA nursing history and the impact and effect on nurses development

This section discusses briefly the apartheid practices that divide nurses of differing race, class and sex. SA women's stories of discrimination in nursing often start from when Europeans landed in SA. They brought with them their missionary and cultural views on race, class, gender, education, patriarchal attitudes and hierarchy all of which played a part by oppressing SA RNs development, and for other's (people with white skin discriminating against those with black skin) enhancing opportunities for development. Since 1994 the post-apartheid constitutional government has been in power, and policies have been re-written to abolish discrimination, yet it still exists in many forms (South African history online, 2017). Foster (2006) dictate's that hierarchical oppression is still in action today, this brings us to question to if this is affecting the provision of PPD today and how this may be influencing the RN's perceptions and experiences of PPD.

For this section I referred primarily to the evidence presented in Foster's (2006) book on Twentieth Century Nursing in SA and Marks (1994) book *The Divided Sisterhood*. Both recount the history of nursing in SA and outline the discrimination that took place in nursing yet identified different sources of evidence and critique. Professor Marks's academic expertise on South African history provides a detailed account of how governmental policy set up a foundation of discrimination against race, class and gender in which healthcare and nursing organisations used to justify their own strategies of dividing and managing women RNs. Foster's book has a different quality of evidence that would be viewed as poor if using a hierarchical academic framework. As a feminist, I viewed Fosters' series of personal stories and testimonials given by black and coloured female nurses, of which Foster as an experienced nurse leader, has edited and summarised with her own critique at the end of each section that is segmented into different periods of SA nursing history. As feminist argue that powerful personal stories give us knowledge by illustrating to the reader in more depth, the effects of discrimination and the behaviour that was inflicted on nurses, and to how this impacted negatively on their development, their careers and the patients that were in their care. And the ways in which they attempted to resist against this oppression to campaign for equality in nursing. In SA Nursing was seen as *'one of the few opportunities available for African women to earn a salary and establish themselves professionally' (Beinart, 2001)*.

Racism and discrimination against women of differing race or class was argued to infiltrate all aspects of society, of which white people, and those of professional status or wealth benefitted the most (Deacon, 1997). The master-slave and master-servant relationship is argued by Foster (2006) to have been replicated within nursing with regards to the way that people of

power, oppress others by having the attitude that is acceptable to treat and behave towards those of lesser power, with less respect and regard for human dignity. For the hierarchy supported in the medical model of healthcare delivery with nurses carrying out doctors' orders. Matrons in the past (now called Nursing Service Managers in today's SA) did not object to this, for they also had to fall within this hierarchical structure otherwise they would have to face the consequences, Foster (2006 p 341- 345). Those who held power, had a belief in that they could treat others they perceived to have a lower social standing, with less respect or consideration.

During the apartheid era, education for black people was designed with only one purpose in mind. Foster (2006, p 164) alleged that the Bantu education model, which imposed a style of learning by rote, was deliberately *'devoid of educational development'*, and prevented the depth of learning, that effected the level of nurse training, practice and limited the job roles that they could carry out. White Europeans and Afrikaners were exposed to more dynamic learning and teaching; hence they were placed at an advantage that promoted the apartheid philosophy that white people should have more development opportunities to help them accelerate up the career ladder and be employed in higher positions than nurses of African origin. The African nurses did not have the education or understanding to be able to perform within these management roles[38].

The selection of languages used in educational settings was also used to support racist views and to justify the creation of nurse education programmes graded at a much lower academic level, in comparison to their white counterparts. This effected the design of nurse training programmes. Stifling development and career prospects for qualified nurses of African origin, yet on the other hand enhancing the nursing careers of those from European and Afrikaner backgrounds (Foster, 2006, Marks, 1994)[39].

Foster (2006, p 6 and p 342) argues that the No 69 Nursing Act of 1957 (SA Government, 1957) set a precedence for further discrimination in nursing, that the South African Nursing Association (SANA) (that is now defunct) and

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[38] It needs to be noted that the UK nursing history is not free of its own bias and treatment of black women nurses. For in the 1950-60's it had the wind rush generation whereby the UK encouraged immigration of women from Caribbean Islands to training and work at EN level (prevented from training as an RN), often having to work nightshifts and unsocial hours unlike their other colleagues (BBC, 2018).

[39] Please note that this debate on the delivery of learning and assessment that is not undertaken in the students 1st language, is argued today to have a negative effect; being that student's performance could be lower as they grasp to learn and undertake assessment in a different language. This issue still hotly debated in SA universities today as university education is mainly taught in English and on occasions Afrikaner.

the South African Nursing Council (SANC) were structures of oppression and supporting further discrimination. SANC was seen to oppress black women's' opportunities to develop themselves and control their development by limiting nursing education. Marks (1994, p 156-7) argued that this nursing Act was a *'very determined attempt to upgrade the status of white nurses, through improvements in pay, conditions and qualifications, and to establish its credentials as a profession'.* This was at the expense of black nurses (often working class whereas white and Indian people were viewed to be middle or upper class). Black nurses were restricted in opportunities to undertake staff nurse training (this is now RN training) and instead they were diverted to lower levels of training including Enrolled Nurse (EN) and Auxiliary Nurse (NA) training.

Pay, pensions, and remuneration were considerably much less, in comparison to white nurses. Living conditions within segregated Black Nurses' Homes, located within the hospital grounds were in poor condition and often overcrowded. Black nurses struggled to gain higher graded jobs or status, and they were treated in a condescending manner (Foster, 2006). This bring us to conclude that the history of SA RN's experiences of PPD differs according to how the individual was treated during the apartheid era. Also that a minority of RNs may have had opportunities for PPD, however the majority did not.

Marks (1994, p168) stresses that it was this same Nursing Act (South African Government, 1957), that led to the creation of nursing regulatory bodies and so led to the; *'increased the drive for increased training and higher standards of entry'*. This led to supporting the professionalization of nursing in SA and highlight the role of nurses delivering professional nursing care. It paved the way for nurse education creating opportunities to study at undergraduate, degree and masters level.

At this point it is important to raise here that the introduction of the regulatory nursing body SANC, was viewed negatively by many nurses. Foster (2006, p 312) summarised in her book the mistrust and resentment that nurses had against SANC. For it was viewed as a powerful oppressive organisation supporting racial views and agreeing to nursing programmes and rules that discriminated against those that were not white, and as a result prevented development of their nursing careers. '*SANC was seen and heard only when individuals erred legally and required punishment or official reprimand'* (2006, p 312). Thus it was an organisation to be feared and loathed. Foster presses on to state that SANC's refusal to acknowledge any wrong doing during the 1997 Truth and Reconciliation Commission, has not supported the building of a more trusting relationship between them and its RNs. Hence when comparing SA RN's experiences and perceptions of PPD to the UK, SA's RNs negative relationship with its' nursing regulatory body SANC, may also

be reflected in current RNs perceptions to how they perceive SANC and its role in regulating RN's PPD.

SA in the 1980's, 1990's to the present day 2018

It is difficult to compare the SA RN's experiences and perceptions of PPD in the 1980's and onwards with the UK because of its complex and unique political history. However, what is clear is that it was from the 1980's that SA nurses voices were starting to be heard, as they challenged the inequality that stifled professional development for those who did not have white skin. More nurses started to campaign via the unions, for better working conditions and equal opportunities.

Foster (2006, p 311-312) provided examples of this inequality. The testimonial of nursing tutor 'Valerie' described as to how the discrimination process was used against many black women RNs by preventing further development and promotion. Yet this same system was used to enhance development for the minority of white women RNs. There was very little opportunity for experienced and capable nurses to be promoted above the basic grade, as being of African ethnicity hindered their development (Foster, 2006, p 311-312). They were also treated far better in the workplace by the doctors, and had better pay and career opportunities, hence saw no reason to why things should change. Newly qualified white nurses did not face the same level of discrimination as they were treated with more respect (being placed in a hierarchy above black women) and experienced more opportunities to develop themselves further. They were promoted quite quickly, regardless to having far less nursing knowledge or experience in comparison than their fellow nurses of African descent.

In the meantime, changes to healthcare worldwide were also affecting nurses. Marks (1994, p196) argues that there was a *'change to healthcare worldwide, with a shift in the locus of decision making to a new managerial bureaucracy',* that this had an impact on RNs, who did not necessarily support these changes. This added to the political unrest that was already brewing across SA. Strikes against the government and employers became frequent, and lasted for months and years (strike action is still common in SA today (Smith, 2010a, 2010b).

Marks describes nurses being caught in the middle of this political crisis in which there was no clear answer to the solution. She empathised that *'by the early 1990's nurses could be threatened with death for going on strike – and also for not going on strike'*. In addition to this, those RNs that did not adhere to their working contract (i.e. by not going into work) were threatened by SANC regulations in that they would be struck off the nursing register, and that they would no longer be able to practice as an RN. During this period of time, nurses were struggling just to survive as nurses, being employed and

paid in a nursing job, and as women who had to support themselves and their families. One can only assume that the turmoil that nurses found themselves in with reduced opportunities for all staff to engage in development activities, as there were barely enough staff to run the healthcare services. It could be suggested that those caught up in these strikes (which are still conducted in today's SA) will have differing perceptions of PPD, than of those nurses who have not experienced such brutal challenges towards their nursing registration, values and principles.

The growth of private health care organisations in SA during the 1980's succeeded in attracting the wealthy and white SA employers into paying for private healthcare, for themselves and their white employees once again demonstrating status. The poor working conditions in the NHS were well known, so these private organisations took advantage of this factor successfully recruiting staff from the NHS who sought to work in what the private healthcare organisations claimed to be better conditions and pay for RNs. Marks (1994, p 197) argues that the private healthcare organisations offering better conditions and opportunities for development, forced the government to having no choice, but to take note to what they needed to do to retain staff. This resulted in adopting modern processes (often replicating some of the UK processes) to manage the NHS, creating policies and procedures that were regarded to be transparent and fair to all employees. They advertised jobs at a far higher pay with more responsibility and flexibility than in the NHS job roles. RNs who were motivated and keen to undertake learning in the workplace were attracted to being able to work at a higher level. Hence the claims made today in that they have more competent and better skilled than staff working in private healthcare, are probably correct as they have the finances to fund and resource a higher level of care, more so than the NHS (Mayosi *et al.*, 2014). Marks did not stipulate in enough detail, if the opportunities for development, also included the funding and support for RNs to undertake courses and to study at undergraduate level. This study aimed to explore the RN's perceptions and experiences, and this may also include reference to the perceptions and experiences of those working in private and public healthcare.

After the 1994 democratic constitution that led to the removal of racial policies that prevented education and promotion, the government started to look at the ways to manage all RNs and their PPD within the constraints of the healthcare budget. This has not necessarily been a smooth path, for many issues prior to 1994 still remain to be core issues today for RNs such as working conditions and pay (Foster, 2006). They had however shaped and modernised their healthcare policies and practices, by reviewing the development that other countries have made within their healthcare policies.

In 2001 SA's Black Economic Empowerment Commission Report (Smith, 2009; Department of Trade and Industry, 2016) sought to improve black

people's opportunity to employment and access to better positions. This has resulted in what is viewed by the government as positive discrimination. Hence a white person who is applying for the same job as a black person, is least likely to be offered the job due to the colour of their skin. The literature review did not reveal any nursing research on white women RNs that has been published since the BBE has been introduced. As a result, it is unknown to what effect this has had on white women RN's, and their perceptions and experiences of PPD[40].
Neither of these key SA nursing texts detail healthcare employers' in-service training or processes with regards to CPD. They do however touch on black nurses attending workplace training only for black nurses, of which was again devised at a lower educational level than the training organised for white nurses. What is apparent is that SA healthcare employers and nursing organisations often mimicked the UK structures, organisations and management processes. Also prior to and during the apartheid era they adjusted policies to support their apartheid philosophies. After the 1994 constitution these apartheid policies were removed and replaced with new policies, that sought to promote more black people in higher positions of power (Department of Trade and Industry, 2016). In comparison to the UK government documents on CPD, LLL and PPD, there is a significant absence within SA literature on these topics. It is only until one is familiar with SA history and SA nursing history can you appreciate to why this has been so.

Power, hierarchy, and nursing autonomy in SA's culture

Issues of power, hierarchy, and nursing autonomy are also still questioned in today's SA healthcare system. Marks (1994, p199) posits that though some things have improved for nurses such as moving away from the traditional restrictive NHS hospital managed training to college (tertiary) and university education. The power relations have not changed; *'the subordinate status of nurses in relation to doctors and the internal hierarchy of the nursing profession itself, with divisions between junior and senior, registered, enrolled and assistant nurses'*. Foster (2006, p 7) agrees that *'there are no*

[40] (In 2014 the Broad Based Black Economic Empowerment was introduced, commonly referred to as the BEE (Department of Trade and Industry, 2016) The BEE was designed to challenge the number of black SAs in low and poorly paid jobs. The BEE states that employers must recruit and employ black people , provide evidence of recruitment to gain the required number of points, is recorded and presented to governmental departments and fines can occur if targets are not met (South Africa Today, 2014). In practice this means that if two people went for a job and were both deemed by the interview panel to be suitable candidates for the job. The black person, or another other race would be more likely to be offered the job in preference to a white person. In this study it was recognised that some SA women RNs may make reference to this legislation and to how it may have affected their engagement, perceptions and experiences of PPD, which is discussed in the discussion section of this thesis.).

overt signs at the cutting edge of the century that doctors are being re-oriented from the old pattern of male domination. Yet there are ominous indications of black nursing service managers re-writing the old rules of hierarchical oppression'. That these working attitudes, resistance to change and the ignorance of RNs economic rights are ignored, suggesting that this is one of the many reasons to why SA RNs are still migrating to work in other countries. The Triple Impact Report (All-party Parliamentary Group on Global Health (APPG), 2016) states that RNs are still facing barriers within their roles that undervalues the profession and does not allow them to work to their full potential. Results from this study may clarify if this is still perceived and experienced to be the case today and to what impact this may have on their PPD.

By undertaking this very brief review of SA nursing history it brings us to recognise that due to SA's cultural past, some of attitudes from others and the environments that SA RNs work in, can still have an impact on the roles that they undertake in nursing today. Also that the culture and attitude towards nurses and nursing practice can differ in comparison to the UK healthcare environment. We need to be mindful of these when comparing these differences, of the RN roles in SA to the UK. Foster (2006) claims that in the SA healthcare environment there is still a hierarchical oppressive environment, whereby the doctor's word is accepted as final and that doctors may treat nurses with less respect; i.e. the nurse's professional knowledge, skills and expertise may be ignored. It seems appropriate at this point, to reflect on one of the participants in this study, Julie 44 SA, who worked in private healthcare who argued that not that not much had changed in SA with nurses just doing what doctors told them to do.

Whereas, in the UK healthcare environment, interdependent working within the multi-disciplinary team is encouraged and RNs can and are expected work independently as a nursing professional. The culture of the "doctor knows best" is no longer the norm, yet there are still nursing roles both in the UK and SA that vary according to the area and/or speciality that they are working in, hence the knowledge, skills and expertise required to undertake the job can vary from one to another from simple to complex.

Concluding that working in any environment, can have an effect on the RN's perceptions and experiences of PPD, of which will be explored within this study.

Third Section: A personal perspective on the historical background of the CPD for RN's within the UK in the 1980's onwards.

This section starts with my brief overview and comparison of the CPD provision within the 1980's for this is when health care and nursing started to experience a turning point. I felt that to be able to set the scene of PPD in nursing. I would need to briefly compare how things were done in the past.

This will help identify if and what has changed and the impact this has had on women RNs, as some women who participated in this study would refer to their past as well as their present experiences.It should be noted that in the 1980's UK systems and processes of healthcare organisation and nursing education were often of similar in SA; however they had been reshaped to include discriminatory policies and attitudes that supported the apartheid regime. As time has moved on some changes have and have not been made. Differences between the two countries needed to be highlighted, so that the reader can have a greater insight into these and understand how the critique has been made in this thesis.

In the 1980's registration of the RN qualification onto the professional body's register was undertaken, with no further requirement to register qualifications again, or to undertake CPD (Shepard and Bethell, 2008). RN's in both countries had to pay a yearly fee to remain registered on their professional nursing register.

Nursing in the 1980's was often described as "a job for life", with stable employment contracts, promotion and regular and incremental pay as standard for RN's (Timmins, 1994; McSweeney, 1996; Maslin-Prothroe, 1997). The Whitley pay scale in which each grade had incremental points that increased every year of employment, there was no evidence required to demonstrate development or competence in the job (www.nhsemployers.org, 2005). The number of years that an RN worked for the employer, reflected loyalty and could often influence successful job promotion, regardless to the level of engagement of CPD or the qualifications that the RN held. The old saying "not what you know, but who you know" was a commonly held view held by RNs that I had worked with during this era.

Shepard and Bethell (2008, p 95) add their perceptions of this era, arguing that once the RN had chosen their area and speciality; *'you were not required to engage in professional development for many years, indeed, until retirement'* and that *'planning, managing and recording CPD what somewhat ad hoc in nature'*. Hence CPD activity and the study on courses may have helped but did not necessarily influence the RN's success in being promoted to a higher grade. Experience and the number of years of working in the job role was valued far higher, despite specialist nursing courses being placed as desirable in job descriptions.

The standard process of RN's CPD activities in the UK in the 1980's and in some healthcare organisations still remains to be the same today

During the 1980's it was regarded as standard practice for RN's to be able attend a "study day" during paid working hours and this was known as protected learning. The line manager would try to ensure that there were enough staff on duty that day, so that the member of staff could be released (and be absent) from the workplace. Hence time to undertake CPD was often granted by the line manager.

Education and training for courses was in general, paid and/or organised by the employer. Funding for these courses generally came from the employer's main budgets; education and training budget, other sources of funding came from representatives of companies that sold medical devices and products, and hospital ward funds managed by the line manager (most wards had a ward fund, in which patients, families and friends could donate monies towards these funds). Funding to "backfill" the absence of staff, was also common practice.

Workplace teaching and learning sessions were organised by the line manager, whereby there would be enough staff during change and handover of RNs from one shift to another, to allow teaching sessions to be conducted, whilst having enough staff to cover the ward. RNs and other healthcare staff and company representatives often taught these sessions. These teaching sessions were regular occurrences within the workplace.

Identification to what mandatory training needed to be undertaken was stipulated by the employer, and the line manager organised and booked staff onto these training sessions. Training sessions were traditionally run in the form of taught group sessions, which were often conducted by staff from the training and education departments (Lillyman and Hall, 1988).

For RNs to progress in their careers, the completion of named courses specific to the workplace area and English National Board (ENB) for Nursing, Midwifery and Health Visiting specialist courses were paramount, for they were often regarded as desirable or essential on job descriptions banded at higher grades. ENB qualifications were recognised by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC), and recorded on the nursing regulatory body's register (the ENB first commenced in 1980 and was dissolved in 2002 with the NMC taking over some of its functions representing all nurses, midwives and health visitors, (The National Archives, 2018). Those who wished to develop their careers could also undertake further training to gain additional professional qualifications in midwifery and health visiting, that were recorded on the professional nursing register, (Shepard and Bethell 2008).

These ENB courses were often full-time courses lasting six to twelve months in length involving assessment of knowledge and skills, and working in the specialist environment. For those RNs that were not already employed by the

hospital that were delivering the ENB course. They were required to sign a work contract in which the conditions stated that they had to complete the course and work for the hospital afterwards for a set period of time. If they did not live in the local area, to complete the course, they were required to find temporary accommodation during the course and to complete their contract (often in the nurses' home, based on the hospital site). Assessments varied but they all involved assessment of knowledge and skills during practice, and some had written exams and essays.

Healthcare employers' workforce planning aimed to include having a percentage of RNs in the workforce, who held these ENB qualifications (and for some, degree qualifications) and practiced at these standards. RNs in the workplace were often expected to "wait their turn", and satisfy any other stipulations made by the employer, before being given a place on an ENB course. The time to wait varied between a few months to a few years and even not to be given or to take the opportunity (personal circumstances preventing or delaying engagement).

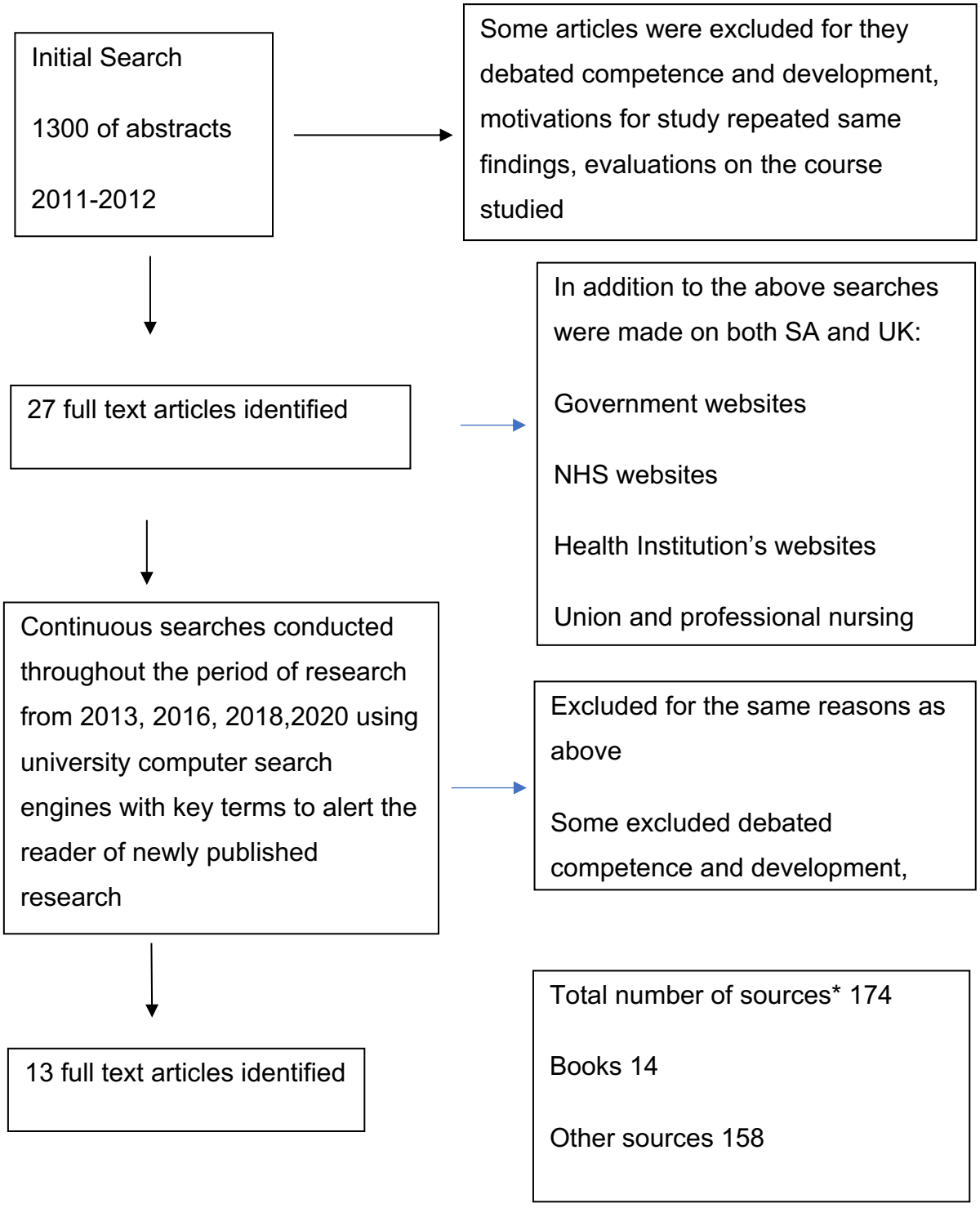
Employers were known to advertise jobs in national journals, this was advertised as an opportunity to undertake an ENB course as part of the job contract being advertised. Hence ENB courses and CPD opportunities were used by employers to recruit RNs and to retain RNs, and they were also viewed as contributing to job satisfaction however it is unclear if there are credible research findings to support this view. Training for ENB courses were often run at the site of employment or at hospitals that were accredited to do so (later on in the 1990's these courses were accredited by universities, whom awarded academic credits at an academic level/s alongside the ENB qualification).

To summarise for many RNs in the UK during 1980's and in some healthcare organisations today, this was what CPD was experienced to be. CPD activities were generally organised by the line manager and courses were paid for by the employer or through another arrangement such as sale representatives/companies or the ward fund. Staff expectations were that they would be granted paid work time and granted absence from the workplace to be able attend the activity. Concluding that CPD was perceived and experienced to be activities that were supported by the employer, undertaken in paid work time and funded by the employer.

The review of the literature, and the findings in this study will establish to what extent this has and has not changed since the 1980's. How much it has changed, and to what effect this has on women' RNs perceptions and experiences of PPD.

Appendix B **Literature Search and key texts**

Section 1: Literature Searches conducted for literature from 2011 to mid 2020 (adapted version of the PRIMSA (no date) flow chart).



Section 2: Summary of the key main articles used in this study

Using the CASP (2016) 10 question checklist it was established that most of these qualitative articles listed below were at a reasonable quality for qualitative research. The results were valid. They had gained ethics permissions and were double blinded peer reviewed and published in respected nursing journals, those that were not have been noted. Those that were not qualitative research were papers written by experts in the field. A few of the articles were literature reviews that informed what knowledge had been established and by whom. Two were Delphi studies. Quantitative research consisted of a quantitative descriptive survey which was a lower quality article in comparison to the cross sectional surveys that included the use of an analysis tool. Articles were from the following countries: UK, USA (America), CA (Canada), AUS (Australia), SA (South Africa) and the NL (Netherlands). The Netherlands articles all interrelated with each other. A summary of the main key articles used in my study are placed in the order of author/s, year, country, study design, with my comments at the end.

Authors and Country of Origin	**Study Design**	**Sample**	**Key findings and critiques**
Bahn (2007) UK	**Qualitative** interviews	20 nurses on formal education courses.	Time release from: work, funding and the additional expenses occurred

			when attending courses.
Banning and Stafford (2008), UK	**Qualitative** Unstructured interviews	10 community nurses who had a range between ten to thirty years' experience	Aimed to explore the perceptions and experiences of nurses' CPD Nurses Experience resulted in the identification of barriers to CPD - leads to personal time being used for PPD. Small number of participants. Limitations of results that it only had perceptions in one area (aim was to explore these perceptions).

			It did not ask nurses studying on the formal course to what they had achieved - in relation to career development.
Beatty.R.M. (2001) USA	**Quantitative and qualitative,** descriptive survey	**119 participants**	Deterrents of CPD for RNs in rural areas. Though focused on competency for RNS this was one of the few that made particular reference towards women RNs, unsupportive partners Repeated findings of other articles such as travelling time, unable to study at home due to

			other constraints in the home.
Burrows.S., Mairs.H., Pusey.H., Bradshaw.T. and Keady.J. (2016) UK.	**Literature review of 13 qualitative studies**	n/a	Continuing professional education: Motivations and experiences of health and social care professional's part-time study in higher education. Challenge of academic study Support or no support in personal and professional areas. Personal and professional drivers, Influence of workplace

			management, funding and availability. Juggling demands of work, family and study, dealing with the negative factors may have a negative impact on learning for those working and studying at the same time. Concludes and recommends that more qualitative research needed on this -of which this is what my research achieves
Brekelmans, G., Poell, R. F. and Wijk. K. van (2013) NL	**Delphi study of nursing experts.**	n/a	RNs viewed their requirements to engage in PPD to be related to increased

			promotion opportunities Achieving a higher level of training and to carry out CPD because it was seen as important in the environment that they worked in. Formal development activities, such as courses were viewed by RNs as highly valued. It depended to how the RN viewed the importance of the activity to whether they engaged in it, and accepted the conditions: intangible and

			material conditions. Brekelmans *et al.* (2013) did not consider the: External motivating factors, such as having to have evidence of development activities for re-registration or to demonstrate competency in the role. Environment that the RN works in can influence participation in development activities.
Chipchase.L., Johnston.V. and	**Expert peer discussion**	n/a	Discussion on continuing professional

Long. P. (2012) AUS			development: 'the missing link' Argued that though some may prefer the traditional taught mandatory courses CPD being delivered via online sessions could offer collaboration with others and has its advantages Suggests staff could undertake their core training activities during 'found time' within their working day. (RNs have a different work

			schedule and commitments depending where they work) Based on physiotherapists and the different ways in which learning could take place. I suspect that for many RNs "finding time" will be challenging.
Davis.L., Taylor.H. and Reyes.H. (2013) USA.	**Delphi study**	n/a	Lifelong learning in nursing. Self-directed learning: so that this would benefit themselves personally as an

			individual as well as in their role as a professional. LLL is defined 'as a dynamic process, which encompasses both personal and professional life.'
Drey.N., Gould. D. and Alan.T. (2009) UK.	**Qualitative** Open ended Questionnaire survey	**451 nurses from 3 trusts**	Same data collected that was used for the previous 2007 study. Nurses relationship between CPE (continuing professional education) and commitment to nursing. No evidence between professional and

			organisational commitment and undertaking CPD. Nurses scores given for organisational commitment were low. Little opportunity for training, suggests that senior nurses in extended roles did not have access to CPD that would help prepare them in their roles. Concludes that the relationship between nursing and CPD are far more complex than expected! Recommends that this needs to be explored - the

			research in my study explores this in more detail
Fleet.L., Kierby. F., Dunikowski.L., Nasmith.L. and Shaughnessay.R. (2008) CA	**Literature Review**	n/a	Continuing Professional Development and the Social Accountability for healthcare professionals. Didn't say how many articles were reviewed. Public concern about quality of healthcare has motivated governments, funders and clinicians to expand efforts to improve professional performance.

			Questions if CPD programmes meets the needs of professionals. Confirms that CPD leads to career development and safe and effective practice. The actions of assessing and evaluating competence, expertise and academic qualifications aids the RN's PPD.
Geurdes.E., Brecklemans. G. Maason. S. Poell. R. Westertrate. J. (2016) NL.	**Quantitative cross sectional survey.**	1226 participants from 1 university hospital and	Factors influencing participation of CPD. If an activity was deemed

		several general hospitals.	important then nurses would consider doing it however this depended on the conditions offered to undertake the study. Findings were that CPD is influenced by three components: RNs' motives in doing CPD, the importance RNs place on CPD, and the conditions that RNs feel are needed to be able in engage in the activity.

			Conditions offered for a NL formal course, were different to expectations that a UK nurse course, though it outlined what these would be, - it was assumed that most nurses received paid time and funding for these courses.
Gijbels, H., O'Connell, R., Dalton-O'Connor, C. and O'Donovan, M. (2010) UK	**Systematic review**	n/a	Evaluating the impact of post reg. education on practice. By undertaking development activities, it can result in improvement of RNs' knowledge and skills,

			perceptions and attitudes
Gould. D., Drey. N. and Berridge. E. (2007) UK	Qualitative	**Questionnaires sent to RNs, from 3 trusts.** **This also consisted of an open ended question.** **451 returned questionnaires** **125 Participants provided detailed comments to the open ended question**	All data was analysed. Provided detailed characteristics of the participants that impacted on their interpretation of the findings. Carried out in London this resulted inparticipants coming from a wide range of cultural backgrounds. Captured participants that found academic and writing in English difficult

			However did not refer to appraisals, KSF or managers. Explores the concept of CPD a theory that has not been proven and the difficulties of CPD. RN expected to invest personal time so that the service delivery could be undertaken, this resulted in resentment towards employers. Barriers in the workplace, "lip service by employers" re-promise of PPD not offered.

			What PPD mounts to "job satisfaction" is debatable. What is job satisfaction and from who's perspective? employers? individual? nursing body Managers acted as gatekeepers for PPD negative or positive. RNs working at the "sharp end" of nursing were found to have a declining commitment towards CPD. Nurses pressurised into undertaking CPD

			for service needs. Demands of CPD erode unacceptability on life outside of work. Managers seen as gate keepers. Made the point that nurses have different views about CPD.
Govranos, M. and Newton, J. (2014) AU	**Case study** **Four focus groups six semi-structured interviews.**	**Twenty three participants recruited from one teaching hospital.**	Exploring ward nurses' perceptions of continuing education in clinical settings' Culture and attitude towards PPD is seen as not "real work", and not supported in a culture of busyness.

			Employers CPD training days were criticised. training days attract criticism being that the way in which the taught sessions are delivered means that not much is learnt from them
Hughes.E. (2005) UK	**Qualitative questionnaires**	**Over eighty questionnaires of closed questions and four in-depth interviews**	Only focused on professional development. 8 themes but didn't state if they had more or lesser importance than the others. Findings revealed what was important to

			RNs professional development. Didn't state all the reasons under the category "other" made you question though this was a very small number what were these and why were they not presented? shift work can cause reduced motivation and tiredness, that takes time to recover from shift work. Attempts to change practice were unsuccessful, having faced

			resistance and a shortage of resources This results in frustration, apathy, disillusionment and disempowerment. Some nurses were undertaking just enough developmental activities to accrue the minimum hours needed reach the PREP standards demonstrating negatively towards learning
Kinsella.D., Fry.M. and	**Qualitative survey**	**Survey consisting of open ended**	'Motivational factors influencing nurses to

Zecchin.A. (2018) AUS		**questions, 34 participants**	undertake postgraduate hospital based education'. Intrinsic motivation can drive behaviour and decision making, early career nurses were driven more by personal values rather than career development. Acknowledges limitations of a survey: says further qualitative research needed to explore if the factors of motivation change during nurses careers.-

			this is explored in my study.
Lee, N.J. (2011), UK.	Qualitative discussion groups	**Discussion groups and one to one discussion, semi-structured discussion schedule**, no of participants not stated which is concerning.	An evaluation of CPD learning and impact upon positive practice change' Original aim was to undertake a survey but they didn't recruit enough people. Had 4 academics collecting data with Lee as the only author-director of research. Participants were line managers and academics though no further detail offered. Refers to the term PPD and

			provides evidence (learning impact, more knowledge, self-confidence, problem solving) however does not clarify the definition of PPD. States that there is little follow up, review of progress, support from learning activity (evaluation of learning and impact managers. Did not have a clear understanding of this, instead they focused more on the issue of resources).

			Uses perception: perceived obstruction from the line manager. Learning and impact upon positive practice change revealed that RNs experienced problems in the workplace when wishing to develop themselves and share their knowledge and encourage colleagues to develop practice. Perceived obstruction from their managers, and they feared

			being labelled as a troublemaker. Participants perceived that they would be a threat. Personal drive and policy drivers were secondary. Questionable to how did they reach this conclusion on personal drive: may depend on the activity? career direction.
McSweeney (1996) UK	**Qualitative expert discussion**	n/a	Low quality article as it is a discussion by a management consultant who reflects on past

			and current times. Argues that previous career paths that planned a step by step progression were becoming eroded and development was now up to the individual to initiate.
Munroe.K. (2008) UK:	**Qualitative expert discussion**	Professional personal experience and expertise	Discussion by expert (University, Head of Nursing, University) Argues that personal development or personal agenda verses competence development. *'Over reliance on the personal*

			motivation, goodwill and personal financial circumstances of individuals perpetuates the charity paradigm and effectively undermines the worth of the individual in the organisation'. Argues that the employer acts as an extrinsic motivational fact or that potentially encourages personal intrinsic motivation, but also inhibits growth of the nurse. Argues it needs a collective collaborative approach to meet both individual and

			organisational needs. Argued perceptions of CPD differ from individual to employer. Use of portfolios can help collect evidence.
Narayanasamy.M. and N Narayanasamy. A. (2007) UK:	**Qualitative expert discussion**	n/a	**Authors are from Professional personal experience and expertise academic training backgrounds, low graded article.**

			Reflects on the contraction of nursing posts and reduction of jobs at higher grades has led to an increase in competition for nursing jobs at a higher level. Argues this has changed the RNs' experience of work, both in the UK and worldwide. RNs no longer work in cultures where the loyalty of working for an employer for a period of time is rewarded.

			Hence PPD is more reliant on the individual. skills, knowledge and attributes, and continue to develop these as part of their ongoing development to remain employable. 'O*nly the well-qualified staff with an impressive portfolio of staff development are likely to climb the career ladder'.* Appraisals are argued to be integral to PPD.

			Negative experiences of trying to undertake PPD
Pool.L., Poell.R., Berings.G. and Cate.O. (2016) NL	Qualitative interviews	21 nurses	**Semi-structured interviews on nurses learning biographies** Explored the relationship between motivations and the developmental activities that RNs undertook from a different angle. They asserted that there were nine motives identified. They stated that new learning

			'makes you grow' it is not clear if this is the researcher's analysis or if this is a direct participant's quote However the questions did focus on this, so I was unsure to if this was participants words or the researchers. I suspect that this was the researchers. This research did collect information about the participants, which assisted in looking at ages however it was

			evident that they missed out women very young or older women. So was not representing all age groups. Development activities are often split under two definitions: formal and informal. Specific motives were related to engagement in particular learning activities.
Pool, L., Poell, R. and Cate, O. (2013) NL	**Qualitative interviews**	**Participants consisted of 10 nurse managers, 22 nurses.**	Nurses' and managers' perceptions of continuing

			professional development Older and younger nurses perceptions of CPD were argued to differ according to the stage in life span due to purpose and contribution towards CPD.
Price.S. and Reichart.C. (2017) CA	Qualitative	**18 focus groups, 185 participants, from 8 provinces.**	*The importance of continuing professional development to career satisfaction and patient care* *Argues needs and perceptions*

			differ according to age span of nurses *Meeting the needs of novice to mid- to late-career through their career span* "has an impact on retention Student and new nurses - education and training for career laddering. Mid to late life nurses - long learning and competency.

Reyes.H., Davis. L. and Taylor. H. (2014)		n/a	**Delphi study** on lifelong learning in nursing. They suggest a definition to what lifelong learning is: a dynamic process that involves formal and informal learning, within personal and professional areas
Richards.L. and Potgieter.E. (2018) SA	Quantitative	***Descriptive survey 40 RNs from 4 state healthcare area.***	***61 questions developed from the literature review****.* *CFE (Continuing Further Education) regarded as beneficial.* Barriers: lack of funding, staff education planning, family

			and work commitments. Benefits, knowledge gain, financial and career prospects.
Schweitzer.D. and Krassa.T. (2010) USA.	Literature review	n/a	**Literature review of ten studies.** Deterrents to nurses participation in continuing professional development. Outlined that extrinsic reinforcement is a weak motivator, and intrinsic reinforcement in a key influence.

			Concluded that to support nurses, leaders needed to become more aware of factors that motivate and prevent nurses from participating in continuing education. Deterrents: cost of attending CE, inability to get time off from work childcare and home responsibilities.
Wijk.K., Brecklemans. G. Maason. S. and Poell.R (2014) NL.	Quantitative	**1226 participants from 1 university hospital and several general hospitals**	**Quantitative cross sectional survey to explore CPD**. Closed questionnaire using quantitative methods using the tested Q-

			PDNA assessment: Closed questionnaire measuring continuing professional development of nurses in relation to key themes: motives, importance, conditions and CPD activities. Linked to the other Netherlands studies results

Appendix C **Topic Guide**

This topic guide has been formulated by; reading around the topic, talking to registered nurses in the academic and clinical environments. It has also taken into account topics raised when in discussion (and on evaluation forms) with Student and RNs, who have been studying personal and professional development modules within the University that I work at. I will be using this topic guide to remind me of the underpinning areas that have helped me create my interview questions for my interview guide and I will be using it within my analysis of the data collected from participants.

Registered Nurses' Perspective of Personal Development:

Lifelong learning (LLL)

Transferable skills

Self-awareness

Academic skills

E-learning & computer skills

Personal skills

Independent and self-directed learner, organisation and self-management

Registered Nurses' Perspective of Professional Development:

Safety of patients

Safe practice

Professional standards

Nursing Care

Professional regulation/ able to practice as a nurse

Employer perspective: mandatory training

Employment/ employability

Career Progression

Updating knowledge

Gaining the appropriate qualifications

Gaining the appropriate experience

Clinical Governance

Competent practice

Specialist practice

Employment/ employability

Career Progression

Service Needs and changes to service

Research

Gold Standards/ frameworks/ national guidance/benchmarks

Knowledge and skills

Employers and Organisations Perspectives on Personal and Professional Development

Commitment to PPD: Part of HR policy

Managing staff: appraisals process

Matching job descriptions to experience and qualifications

Promoting Leadership and leaders to be role models

Personal Development Plans

Acknowledging Nursing and other health organisations/government recommendations

Giving access to funding, time and travel

Influential within recruitment and retention

Empowering staff to make changes to the service

Motivating staff

Career development

Equipping staff with knowledge and skills to provide the service

Fair and equal access to PPD for all staff

Benefits of Personal and Professional Development:

Professional aspect

Better chance of job promotion

More interesting job/roles

More self-confidence and self-awareness

Qualifications that lead to further opportunities

Higher pay

Able to take on responsibility in leading and managing others

Able to take responsibility to assessment and train others

More autonomy in decision making

Higher level of knowledge and skills

Academic aspect:

As a learner more able to apply:

Critical thinking skills

Reflection

Self-awareness

Assessment

Measurement

Qualification/certification

Study at an academic level: dip/degree etc.

Research – interpretation of results and application to one's own practice

Self-management and organisation

Problem solving skills, and the ability to prioritise

Personal aspect:

Self-satisfaction in own achievements

Self-acknowledgement

Self-awareness

Self esteem

Increase in confidence

Status

Character building; determination

Emotional Intelligence

Actions, activities, techniques and strategies that are linked to personal and professional development:

Personal:

Undertaking learning that may enhance:

Transferable skills

Self-directed learning activities

E-learning skills

Computer skills

Awareness of personal learning styles and preferences

Self-management knowledge and skills within different situations such as within the:

Home and family life, professional life and as a learner.

Use of reflective models and journals

Use of critical analysis tools to assess

Writing CV and reflecting on career development

Professional:

Volunteer to go on to different committees

Link roles

Job shadowing

Secondment

Mentoring

Coaching

Responsibilities within the work place and professional organisation

Training within the work place

Teaching and training others

Management of staff, equipment, budgets and training

Preparation and self-management in meetings and appraisals

Understanding and interpretation of the service needs

Barriers against Personal and Professional Development

Unequal access to training and development opportunities

No or little knowledge or skills to use computer or websites

Difficulty in accessing the internet

Difficulty in travel to place of study

Unable to access training and development

Lack of confidence

Self-perception that they have a poor writing ability

Low level of critical thinking skills

Lack of Time

Lack of Finances

Family commitments

Work commitments

Other pressures/ responsibilities inside and outside of work

Space to carry out study: at home and in work

Working Environment

The use and implementation of appraisals that do not enhance the individuals PPD

Style of management at different levels within the organisation

Style of leadership at different levels within the organisation

Line manager's approach and attitude

Team members: poor skill mix

Short staffing

Attrition and recruitment issues

Low morale

Style of delivery of training and education: no choice/ unsuitable for the individual/

No career development

No opportunities to progress into other job roles that are: specialist or higher paid

Stagnation within job role

Unequal/ unfair selection of staff to undergo further training and education

Lower graded staff felt over-looked by senior staff

Appendix D **Background information on SA and the UK**

SA and UK: the commonalities and differences between the two countries

The purpose of this section is to highlight some of the commonalities between the two countries, with some reference to the variations between the two countries that affect women's lives and the sample used in this study. The literature review discusses in more depth the variations and the impact that this has on women RNs undertaking PPD activities.

This background information on SA and the UK aimed to offer a comparison between the two countries with regards to language, population, religion, geography, poverty, housing and unemployment, and women and poverty, governance structures and funding. It raises some issues on healthcare, RNs' employment and pay in the NHS and private sector. Finishing with nursing, healthcare education and training. It needs to be noted that there are some personal reflections within this section that I have made.

Schraf (2016) argues that for a comparison to take place, the researcher needs to establish the differences between the two countries in relation to language, population, religion, geography, poverty, housing and unemployment, governance structures and how this may affect the research design. In addition to this, reference has been made to women and poverty. For it is these differences between countries that can result in capturing the differences and presenting new knowledge on the research topic.

Cultural statistics with regards to race, class, ethnicity, sexual identity, religion and language are recorded within the SA and UK governmental statistics. However, due to the countries having different definitions for these, no direct comparisons between the two countries could be made. Therefore, the decision was made to only use the government cultural definitions on the short answer questionnaire that participants were asked to complete prior to the interviews, so that if asked, I would be able to say what some, but not all, of the characteristics were within the sample. It was decided that I needed to make it clear that this was a comparison between RNs of different countries, which could have been termed as a cross-cultural comparison. However, one could argue that this would have required a much larger number of participants to represent race and ethnicity of the culture being studied.

Classifications of the race used in each country were: for the UK British ethnicity is described in order of highest percentage first: (a) white, (b) Asian/Asian (c) British, Black, African, Caribbean, black British, (d) other ethnic groups (e) mixed multiple ethic groups (Office for National Statistics

2011b). And in SA these were described as: white SA, black SA, coloured, Asian, Indian, and any other SA groups (statssa.gov.za 2016b). These classifications group together other races under these umbrella terms. For example, the UK definition of black is divided into African black, Caribbean black and black other.

Population

The 2016 SA census recorded its population as 55.6 million people, though these figures are argued by the 2016 government statistics report to be much higher, due to the rural areas that some people lived in, which may have made it difficult for people to attend registration (Statssa.gov.za, 2016b). In 2015, the UK estimated that its population consisted of 65.1 million people (Office for National Statistics, 2016b; Statssa.gov.za, 2016a). Hence in comparison to SA, the UK has a higher number of people living in a smaller geographical space.

Female to male ratio

The female to male ratio in SA was 51% females to 49% male, the UK ratio was 50.7% female to 49.75% male (Office for National Statistics, 2015; Statssa.gov.za, 2016a). This establishes that the UK and SA have similar numbers according to their population and male/female ratio.

Race and Ethnicity in SA

Sahistory.org.za (2018) describe ethnicity as *"shared cultural practices, perspectives, and distinctions that set apart one group of people from another. The most common characteristics distinguishing various ethnic groups are ancestry, territorial possession, language, forms of dress, a sense of history and religion."* SA has number of different ethnic groups that speak different languages that these of often routed to their ancestry. During the apartheid era, ethnic groups were moved to "homeland areas" creating ethnic divisions within the country (Nattrass, 2016). That since 1994, these people from these ethnic groups have been able to move and live to where they wish.

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Classifications of the race used in each country were: for the UK British Ethnicity is described in order of highest percentage first: (a) white, (b) Asian/Asian (c) British, Black, African, Caribbean, black British, (d) other ethnic groups (e) mixed multiple ethic groups (Office for National Statistics, 2011b). And in SA these were described as: white SA, black SA, coloured, Asian, Indian, and any other SA groups (statssa.gov.za, 2016b). These classifications group together other races under these umbrella terms. For example, the UK definition of black is divided into African black, Caribbean black and black other.

For the UK sample I had recruited the majority of the participants from the English UK university site. This was in a predominately white British area, all of the 15 participants described themselves as white British. The 2011 England and Wales Census recorded white British as 86%. In the SA sample I recruited black African (9), coloured (13) and white SA (2) and Indian (1).

The SA 2011 census (Statssa.gov.za) recorded black African as 76.4%, coloured as 8.9 % and white as 9.1%. Concluding that the sample had some representation of women in their country, but not all race.

Universities in the Western Cape attracts students from all over Africa, I had two women who approached me wished to be interviewed to tell me what it was like for them. I decided to do so, honouring their wishes, and allowing myself to be in the privileged position to hear what they had to say about SA and SA nursing. These women's interviews were excluded from the sample, however, these interviews had made me more aware of the number of African women RN's working in SA. They had moved away from their families and homes to gain education and jobs in SA. And continued to stay in SA, sending monies back home to their families. They alerted me to the differences in ethnicity and to how this affected their status and to how they were treated by others.

Religion

In order of popularity, SA's most common religions are: Christianity, Islam and indigenous beliefs (South African.info, 2016b). The UK's most common religions are: Christianity, Muslim, with a small minority of other languages. The 2011 English and Wales Census points out that more British people are saying that they have no religion (Office for National Statistics, 2011a). In this study religion was not questioned as it did not seem appropriate. It was however recognized that some participants may raise their religion and/or beliefs within their answers to the questions. My experience in SA was that many participants were like myself who held Christian beliefs, this connection

between myself and the participants, I felt had enhanced the relationship further that I already started to build with them.

Language

SA has 11 official languages, and there are many other languages spoken. The most commonly spoken languages are in order of popularity; Zulu, Xhosa, Afrikaans and then English (South African.info, 2016c).

Sahistory.org.za state that the majority of SA people speak more than one language (Sahistory.org.za, 2018). That today the government encourages English to be used in official and commercial life (South African.info, 2016c). SA universities too have stated that all written work must be in the English language, a few universities also still accept Afrikaans as a language that can be used in academic studies (Makoni, 2012; The University of Cape Town, 2017). Hence many SA RN's are having to carry out academic studies, reading and writing in English, this can be a challenge for many of whom English is not their 1st language.

In the UK, English is spoken across the whole of the UK, Welsh, Scots and Gaelic are also spoken (British Council, 2016). The majority of its residents speak English as their 1st language, the English and Welsh 2011 census stated that 92% spoke English as its first language, the remaining 8% spoke other languages, in a minority of areas within the UK, some people had a poor understanding of English language (Office for National Statistics, 2016a).

Geography

The UK is situated within the European continent, and South Africa is situated within the African continent. SA and the UK differ in relation to geographical size, economics, culture and population. The UK is close to 95,000 square miles (245,000 square kilometers) (British Council, 2016). Whereas SA is much larger than the UK, with 1 219 090 square kilometers (South African.info, 2016b). The UK has one border, that separates Northern Ireland from Ireland, England, Ireland and Scotland are surrounded by the sea. SA has many borders that it shares with other African countries these are: Namibia, Botswana, Zimbabwe, Mozambique, Swaziland and Lesotho. SA continues to experience immigration of people from their neighbouring countries. Nattrass (2016) argues that has led to tensions within SA, sometimes in the form of Xenophobia, for locals struggling to get jobs themselves may view others as a threat. This could also have an effect on the safety of African women wishing to undertake study in SA; that includes travel and clinical work in areas, that they may be unfamiliar of any tension between locals and "incomers".

SA has been experiencing mass migration from rural areas to the city areas Cape Town and Johannesburg, within the provinces, Gauteng and the Western Cape. The governments' South African.info (2016) claim that these areas have seen the fastest increase in migration. For many people are moving from their ancestor's homes, to getter better education and jobs. That rural areas are suffering as a consequence, for this has an effect on rural economy.

Many SA women RN's wishing or needing to undertake PPD qualification for example, to keep their jobs, further career development, and/or earn better pay. Are having to leave their families (elderly parents/children) in the care of others (boarding schools/ paying relations/family members). For many SA, unlike their UK counterparts they would not be able to afford the time or financial cost to travel home for the weekend. These lack of finances, can also have an effect on the places that they can live in, for they may not be able to afford the rent. For some women they have no choice but to live in areas that are unsafe for women and have poor transport infrastructure.

Women in SA face a far higher threat of violence, than in the UK

(Department of Women, 2015).

Poverty, housing and unemployment

In 2016, figures showed that unemployment in SA was very high at 27.1% whereas in the UK it was much lower, sitting at 4.8% (Office for National Statistics, 2016c; statssa.gov.za, 2016b). Poverty has many different classifications used by different countries; in this study it is evident that these two countries' standards of living and poverty differ greatly from each other (Full Fact, 2016). In comparison to the UK, SA has more than double the amount of the population, living in poverty (Full Fact, 2016). SA's current figures to date are that 56.8% of the population live in poverty (statssa.gov.za, 2016c) in comparison to the UK 2014/5 figures that class absolute poverty, before and after housing costs, varying between 15% to 20% of the UK population (Full Fact, 2016). Wildschut and Mqolozana (2008) highlight that there are disparities between of the provinces, that in comparison to the Western Cape Province some other provinces have a much higher population of poverty.

Again, SA and the UK have different definitions in their standard of living with regards to water, electricity, sanitation and housing. SA figures state that 70% of SA have access to running water in the area that they live in (statssa.gov.za, 2016a). In the UK, they offer no figures to compare against as it is considered to be the norm for all housing to have water, electricity and sanitation (Poverty Org. UK, 2016). The areas that SA people live in, are difficult to interpret and measure against UK definitions for they use different criteria and measurement. The UK definition of sub-urban and urban cannot

be applied to SA, as not all housing has been planned and approved. For this study participants were asked to if they lived in a city, semi-rural or rural areas (recognising that for some SA participants they may not declare their place of living as some considered themselves having a work place of living and a family or ancestral home). The primary purpose was to help establish to where the participants currently lived and worked. The sample would show that women RNs in this study had a range of working experience from working in city hospitals to rural clinics. It was decided not to collect information to where they had worked or lived prior to this.

In SA, People often who have very little money, have built small places of shelter, groups of these shelters are called shanty towns. Some of these towns have little or no facilities, whereas others have shared facilities, street lighting and public transport routes, the standard varies considerably (The World Bank, 2016). Some areas have poor transport which results in women having to walk through unsafe areas, poorer areas are associated with a higher risk of violence (Department of Women, 2015). The same can be said of townships, these to have been built on lands that are not privately owned. Many townships can be found on the outskirts of cities, towns. Some townships have established housing as those that lived there have found better paid jobs and decided to stay and build better homes for them and their families, hence no assumptions can be made of the standard of living unless you have local knowledge of the area (The World Bank, 2016). In this study no questions were posed to gain details of housing for this was deemed to not be relevant in this study.

Women and poverty

The research study did not aim to collect data that would indicate participants'; standards of living, or if they were living in poverty. For this research project, many nurses did not declare the wage that they earned, but some gave the grade or/and job title/s, that helped myself, identify that the sample was representative of RNs by having women RNs being employed at the top, middle and lower grades.

The research study aimed to listen to any difficulties that women said they experienced, how it impacted on their PPD answers given in this study included; the hardships that they were experiencing from not having much money which impacted on other areas of their lives such as struggling to pay for university or childcare fees. Women would also be asked about the benefits of PPD of which it was expected, that the increase in wage from having achieved their PPD could be raised in some of the answers given and comments about lifestyle choices that they had made. It needs to be noted that in this research, there were references made from both SA and the UK women; with regards to the struggles that they had in relation to having little or not enough money.

The levels of poverty experienced by women in SA and UK differ. If a woman told me "I have no money left" I recognised that to understand what this was in reference to. For example, did they mean, I have no money to buy expensive gifts, go out or go on holiday? Or did they mean that no money to put any food on the table which meant that they there was no money left to buy any other provisions such as clothing? It could be easy to assume that those women in SA are more likely to be suffering from poverty, more so than those in the UK. However the UK's RCN reported in 2016, that they had received an increase in RN's requesting financial help (RCN, 2017c). That this has been caused by the government; for since 2010, they had not received an increase in their pay scale making them out of date when taking into account the rising costs of living. The RCN argues more and more nurses are struggling to manage their finances. Bringing us to conclude that like their counterparts in SA, some RN's are having to carry out work additional to their main jobs through agency/bank and moonlighting (Rispel and Blaauw, 2015). To be able to meet the financial costs of their household.

Women are often found to take the responsibility to manage the budget for the family, figures for both the UK and SA show that there is an increase in female headed households (Casale and Posel, 2002). Hence women are having to financially support other members of their families as well as caring out roles that often involve caring for others in the family. At the other end of the scale, UK statistics demonstrate that there is an increase of women living alone; in 2017 7.7 million people were living alone, 53.8% of these were women (Full Fact, 2016; Poverty Org. UK, 2016). Hence there are women who are paying mortgages/rent, bills by themselves with no assistance from others. Bringing us to recognise that women RNs from different backgrounds are striving to become financially independent. That many women are making career choices, and engaging in PPD, to stabilise and improve their financial status.

Enrenreich and Hochschild's (2004) book 'Global Woman', argues that the "male bread winner" has been a myth. That many women are having to make the sacrifice to live and work somewhere else in order to feed, clothe and house their family members. The personal cost to women, who are having to migrate to work is high.

To summarize, the differences for women in the UK and SA. A UK woman studying or working at a sought-after institution, within the UK may spend the maximum of a 24hr of travel by coach, a train ticket or airplane ticket being much quicker and affordable for many RN's. Whereas in SA, because of this country being much larger in geographical size, and far greater rural areas whereby local bus transport maybe slower, less frequent and less safe for women to use (Department of Women, 2015). For some women it could be 3

– 4 days of travel (depending to how they could afford to travel, for many black SA women bus travel is the only affordable option, an airplane flight would be only accessible to women who could afford this luxury).

Governance structures

Both the UK and SA have a democratically elected government. Whereby they have an elected political party, the leader of that group, in the UK is called the Prime minister, in SA they are called the president. In both countries they have a cabinet, serve parliament. The other aspects of the government structures differ from one another. All though it needs to be noted that the definition of democratic could be challenged, for many references ignores the fact that all UK women didn't get the right to vote until

1929 and that there is still an unequal pay gap between women and men's pay (Fawcett Society, 2016) and in SA Nattrass (2016) points out that it was in 1994 that all SA women got the vote.

Historical aspects of the UK, results in the UK being a constitutional monarchy, whereby Queen Elizabeth II currently serves as the Head of the State and Head of the Sovereign and receives payment from the government (UK, 2017). Whereas in SA this is a parliamentary republic (South african history online, 2016). Historical aspects of SA results in its advisory bodies drawn from SA traditional leaders that also inform the government. This includes payment to 10 African Kings, a Queen, and many headsmen that ensure that laws that run parallel to the SA governmental laws are adhered to (Nattrass, 2016). In comparison to the UK the SA governmental structure has had a lot more radical changes that have been undertaken since its independence (Kerr, 2012). For SA moved from a being a country governed by tribal society, missionary and colonial society, to apartheid which led to divisions between race and class, and then in 1994 it moved to a democratic society (Nattrass, 2016). Which again changed the structure of government and its services. The government continues to flex and change as it grapples with the challenges of being in a democratic society (Nattrass, 2016).

This brings us to summarise that many SA participants within this study unlike the UK participants, will have had experience of being governed by the apartheid government. Within this research study, women may be found to make references that compare the differences and reflect on their experience and perceptions now they are being governed by SA democratic rule.

To summarise to the differences between RN's in SA and the UK brief comparisons have been made between the key stakeholders of RN's PPD. These are public and private healthcare organisations (with particular reference to employers' pay frameworks, recruitment strategies and working contracts). Nursing regulatory bodies that stipulate and govern RN educational programmes and register and regulate RN's practice (working

with the government's department of health and academic organisations that deliver these nursing courses). That nursing and health care education is offered by public universities and colleges, and private colleges. Nursing and/or healthcare unions (these are influenced also by specialist nursing groups).

The NHS in SA and the UK; management of education, training and development of budgets in the NHS and the private healthcare providers that can be used to support RN's PPD

Both governments run a National Health Service (NHS) and set out their strategic plans and policies to manage the NHS, this includes financial planning and direction for the education and training of trainee and qualified staff within the NHS and healthcare. The governments in both SA and the UK have a Department of Health (DoH), systems vary at this point to whom takes responsibility to manage and allocate monies (Department of Health, 2017; Westerncape.gov.za, 2018).

Within these yearly budgets, are allocations to be spent on education, training and development of staff (Westerncape.gov.za, 2017a; Department of Health UK, 2018). NHS workforce plans also address the issues of training and education (The Kings Fund, 2015). Responsibilities of managing these monies are devolved to provinces/regions/countries within the UK and SA (the UK has four countries, England, Wales, Scotland and Northern Ireland with regions within each country).

Decisions made with regards to the allocation of these budget monies are made by the head leader/ executive committee of these provinces/regions. Hence the total amount of monies, allocated to be spent on training and education, can vary from one area to another, often the size and population of each province/region and the resources required influence these decisions. Depending on the organisational structure of the provinces/regions, some of these monies may also be allocated directly to universities to deliver and offer places for NHS staff on named post registration courses and the training of students to gain professional qualifications (Westerncape.gov.za, 2017b).

Organisational structures, the healthcare service delivery and service current and future plans within a region/province, often vary from one to another, which in turn effects the amount of monies that they receive.

The next level down starts to directly influence what opportunities an RN may have in gaining support for PPD activities. The executive committee or board make the decision on how to devolve these monies, to the various services that they govern. For monies are allocated to each service, for example in UK Trust this will consist of; hospitals, clinics or/and health centres. Again, the amount can vary from one service to another. Executive directors on the

board, make final decisions to how this money is spent, membership of the board may or may not include nursing directors. If they do have a nursing director, the role of the nursing director is lead and manage RN's within the organisation, this includes management of CPD for RN's (Burdett Trust for Nursing and The King's Fund, 2019). Often in UK and SA NHS hospitals they will have a medical director and a nursing director. However, in private hospitals nursing directors are not necessarily found to be on the executive board. Training and education of RN's is more likely to be managed by HR departments and nursing managers. It could be suggested that without having nurses on the executive board, that RN's have less opportunities to gain support in PPD activities. However, no literature could be found to support this suggestion.

Included in the financial planning of services, is a separate budget for monies that have been ring fenced to support training and education on specific issues of concern. For example, training and education on managing and treating a specific disease or condition that is regarded as priority within that country. For example in SA, training and education for RN's on the management and treatment of AIDS, TB and STI's have been prioritised over the forthcoming years (South African National AIDS Council, 2017).

It needs to be noted at this point, that the government has the power, if they wish, at any point during the year's budget, to retract these allocated monies for staff training, education and development. By placing them back into the main government's funds, that that this can happen at any level within these provinces/regions. That these decisions to retract monies also be made by the executive board of hospitals and other services. Hence monies that have been promised to education and training budget. In which RN's have received agreement from employers that they will support them in their PPD activities, can change, and agreements can be withdrawn, at any time.

Bringing us to summarise that monies for education and training in the NHS are managed a similar way by both SA and UK governments. That the decisions on the amount of monies allocated for services that RN's work in, is influenced in many ways. That an RN working in an area that has either; a large amount of monies allocated to their place of work or working in speciality that has monies ring fenced, may be in a better position to be successful in gaining support for PPD activities. Then those specialities or areas that have not been so successful in gaining monies. The concluding that budgets have a direct impact on staffing, and monies allocated for resources and PPD activities. All of which can affect directly or indirectly women RN's experiences and perceptions of PPD.

Women, men and the nursing profession

Nursing has historically been a caring profession, which has traditionally been heavily populated by women and continues to do so. Though numbers

of men in the profession have gradually increased over time, their numbers remain small. SANC currently offers no breakdown of the type of nursing registration, hence the actual figures for RN's could not be established in 2017, for their figures include EN' and AN's, whereas UK figures only include RN's. Wildschut and Mqolozana cited SANC's 2007 figures for professional nurses as 94.1% female to 5.8% male (2008). Whereas the NMC's 2010 figures are 89% female to 11% male. SA figures for men in nursing (SANC, 2008) are higher than UK (NMC, 2015).

Jobs in the nursing profession offer professional status, financial security and other benefits. And is an attractive option for both women and men, in comparison to other jobs that pay less, have fewer benefits. In SA women's paid work do not always include a legal employment contract, of which many nursing jobs are guaranteed to have (Department of Women, 2015).

An introduction to the employment and working conditions for RN's in the public National Health Services (NHS) and private health care sectors in SA and the UK.

Both SA and the UK have an NHS and they are the largest employers for RN's (Jasper and Mooney, 2013). Where these two NHS's differ is that the UK NHS was set up to offer free health care service for all citizens, whereby all citizens had to pay National Health care Insurance, however depending on the status of the citizen they only have to pay additional fees for medicine, dental treatment (NHI) (NHS, 2017). Whereas the SA NHS has undergone a number of changes since was set up. It currently has a Uniform Patient Fee Schedule (UPFS) that establishes what fee would need to be paid, this scheme also includes some treatment that is free of cost, however many citizens have to pay some costs for treatment, some of which will struggle because they are living in poverty. Which has a knock-on effect on the NHS for this results in unpaid fees and impacts on the yearly budget. This can result in a shortage of basic supplies and medical equipment (Wildschut and Mqolozana, 2008). At the time of writing, the SA government is in the process of introducing national health care insurance, which will have an impact on the NHS, though the results are still waiting to be seen (South African Government, 2016).

SA has a larger number of private health organisations than the UK; such as: Netcare, Mediclinic, Fresenius medical care and the Life health care group, these organisations grew during the era of apartheid and post second war, whereby private health care was encouraged and purchased by the middle and upper classes who could afford it and employers who offered it for all white citizens. As well as working for private health care organisations, SA RN's can also work as self-employed as often calling themselves nurse consultants, working in private clinics that can be owned by much smaller

private enterprises. On obtaining a masters qualification, RN's can set up their own clinics as private business.

The standard of health care within private healthcare organisations is argued by many to be better than public healthcare, providing a higher standard, by having a quicker service, better resources, equipment, and a higher ratio of professional staff (in particular medical) with knowledge and skills to carryout healthcare treatment and management (Econonex, 2013).

The SA NHS service struggles financially, like the UK NHS. However Mayosi *et al.* (2014) reports that in SA this differs greatly. For some but not all provinces, NHS health care organisations are seriously depleted by having been mismanaged, having poor supplies, little resources and minimal staffing levels. DENOSA reported in 2016 that in some areas of SA, RN's were not being paid for the work that they had carried out, and that some NHS providers were not recruiting RN's due to having no money left within their budgets (2016b). Rural areas appear to struggle more so to recruit and retain staff, some do not have access to doctors for days or weeks, which impacts on the RN's role working within the primary healthcare setting, patients may have to que for many days before being seen by a nurse or doctor. It needs to be noted for the non-SA reader, poor supplies often refer to the following: no bedding or clean laundry, no soap or water, no food, and no medicines.

Econonex (2013) argue that in SA for those that can afford it, it is common for its citizens to pay for private health care insurance because the standard of private healthcare is far better than NHS health care. It predicts that 28% - 38% of SA citizens have some form of private health care insurance at some level (some health care insurance policies have 30 different levels of insurance). At this point, it is important to not to ignore cultural difference in SA, for healthcare treatment is still undertaken by traditional healers (often at a cheaper price than NHS western medicine fees). The website South African History Online argues four points of which in my experience, reflect the reality in today's SA. Firstly, that traditional healers are more commonly sought by those living in rural areas, whereby NHS provision is argued to be more understaffed in these areas (in particular reference to medics), in comparison to cities. Secondly, that SA's *"prefer traditional healers to western medical practitioners"* (South african history online, 2017), this may be because there is more cultural knowledge and belief in traditional healing than in western medicine that may be treated with suspicion and fear. Thirdly, that the patients that are treated by the SA NHS, are more likely to be in poverty, and may not be able to pay or access treatment. And the last final point, is that the SA NHS is understaffed by working professionals (more so within rural areas), placing additional working pressures on RN's who have to work in the absence of other professionals such as doctors (National Department of Health, 2011).

The UK's NHS also has its challenges, but these differ to SA mainly because of the difference in culture and geography being that rural areas are much smaller. It has short staffing issues, but these numbers differ according to the profession. The RCN argued that in 2017 nursing vacancies rose to 40, 000 (UK Government, 2015; RCN, 2016, 2017a). Whereas Rispel and Bruce (2015) cited that in SA, the 2011 National Department of Health report estimated that there was a shortage of 44 780, a figure that is much higher than in the UK (Wildschut and Mqolozana, 2008; National Department of Health, 2011; Blaauw *et al.*, 2013; Rispel and Blaauw, 2015).

The UK NHS provides healthcare for the UK population of which the majority access. Private health care insurance is often only used when offered as an incentive by employers for employees and for those that decide and can afford to pay for private health care. This may explain to why the UK has a smaller number of its citizens paying for and using private health care by organisations such as Spire, Bupa, BMI and Virgin Care (Spire Health Care, 2016).

Bringing us to summarise that RN's can work for the NHS or private health care employers. In SA it is more common for RNs to decide to work as self-employed, that those who hold a master's qualification can manage and run their own private clinics. However, the majority of RNs in both SA and the UK have had experience of working in the NHS (many RN's will have undertaken student nurse training placements in NHS settings), less RN's have experience of working in the private sector. RNs working in SA may have different experiences, knowledge and approach than UK's RN's. RN's in SA are; (a) caring for a much higher number of patients whom may be living in poverty (and can't afford to regularly access and pay for medical treatment),who may be having traditional and western treatment at the same time, and (c) some RNs were working in areas that experience higher levels of short staffing in that they have little or no access for weeks on end to a medic (this is commonly associated with rural areas).

Within this study it aimed to recruit RN's, it was not set in the criteria to what backgrounds or speciality RN's would need to come from, but rather that it required RN's from a range of experience, backgrounds and specialities to be representative of RN's. It was recognised that I would be recruiting women who had experienced working for public and/or private healthcare employers. That the areas that the RN currently worked in (city, semi-rural and rural) may have had an influence on the working conditions.

In this sample women were asked to what their current contracts of work were, and to what speciality they worked in. The majority of women worked full time; a few women worked part time. The majority worked for the NHS, seven worked in education, and training this also involved the SA role as clinical supervisor for student nurses, two SA women worked for private employers, one worked as self-employed, one worked in the Army. It was

recognised that women only disclosed their main job. Before during and after the interviews, some women told me that they undertook bank/agency work, some others undertook voluntary work in different settings such as nursing work in poor rural areas clinics and counselling/nursing work within the church. It needs to be noted that in SA women often do not wish to disclose if they work elsewhere as this may mean that they are breaching their employment contract (The Centre for Health Policy, 2014; Rispel and Blaauw, 2015; Unique HR Directions, 2016).

Appendix E **Ethical Permissions**

School of Health in Social Science
Medical School, Teviot Place
Edinburgh
EH8 9AG

Telephone: 0131 650
Fax: 0131 650 3891

27th November 2012

Dear Lindy,

Re: Ethics application Lindy Hatfield 'Comparing registered nurses' perceptions and experiences of personal and professional development'.

I can confirm that your ethics submission has been reviewed by two member of the School Research Ethics Committee and has been approved. It was felt that from your self-audit this could have been accepted as a Level One submission. There were some points identified that would warrant further clarification, and we would ask that you should pay attention to these:

- It should be specified that the respondent's full name, along with other identifying information, should be kept on the interview record but that to ensure anonymity another identifier should be used.
- Digital data should be kept, along with transcriptions, in a secure computer and preferably encrypted. The file on the recorder should be deleted.
- All records to be retained should be anonymised and key to the allocated codes should be kept elsewhere.
- There should be greater clarity concerning provision for those for whom English is not their first language.

Please let me know if you need further clarification.

Best wishes,

Yours sincerely,

Ethel Quayle
Chair of the School of Health in Social Science Research Ethics Committee

UNIVERSITY OF CAPE TOWN

Faculty of Health Sciences
Human Research Ethics Committee
Room E52-24 Groote Schuur Hospital Old Main Building
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20 March 2013

HREC REF: 184/2013

Ms L Hatfield
c/o A/Prof P Mayers
Nursing & Midwifery
Health & Rehab
OMB

Dear Ms Hatfield

PROJECT TITLE: PERCEPTIONS AND EXPERIENCES OF REGISTERED NURSES PERSONAL AND PROFESSIONAL DEVELOPMENT

Thank you for submitting your study to the Faculty of Health Sciences Human Research Ethics Committee for review.

It is a pleasure to inform you that the HREC has **formally approved** the above-mentioned study.

Approval is granted for one year till the 28th March 2014

Please submit a progress form, using the standardised Annual Report Form if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.
(Forms can be found on our website: www.health.uct.ac.za/research/humanethics/forms)

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please quote the HREC. REF in all your correspondence.

Yours sincerely

PROFESSOR M BLOCKMAN
CHAIRPERSON, FHS HUMAN ETHICS
Federal Wide Assurance Number: FWA00001637.
Institutional Review Board (IRB) number: IRB00001938
This serves to confirm that the University of Cape Town Human Research Ethics Committee complies to the Ethics Standards for Clinical Research with a new drug in patients, based on the Medical Research Council (MRC-SA), Food and Drug Administration (FDA-USA), International Convention on Harmonisation Good Clinical Practice (ICH GCP) and Declaration of Helsinki guidelines.
The Human Research Ethics Committee granting this approval is in compliance with the ICH Harmonised Tripartite Guidelines E6: Note for Guidance on Good Clinical Practice (CPMP/ICH/135/95) and FDA Code Federal Regulation Part 50, 56 and 312.

s.thomas

UNIVERSITY of the WESTERN CAPE

DEPARTMENT OF RESEARCH DEVELOPMENT

08 November 2018

To Whom It May Concern

I hereby certify that the Senate Research Committee of the University of the Western Cape, at its meeting held on 01 March 2013, approved the methodology and ethics of the following research project by: Ms L Hatfield (University of Cumbria)

Research Project:	Comparing registered nurses perceptions and experiences of personal and professional development.
Registration no:	13/2/1

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

The Committee must be informed of any serious adverse event and/or termination of the study.

Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape

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20 December 2012

Our Ref: IC/SB

Lindy Hatfield
Faculty of Health & Wellbeing
Lifelong Learning and Interprofessional Learning
Fusehill Street

University of Cumbria
Research Office
University of Cumbria
Lancaster Campus
Lancaster, LA1 3JD

Tel: 01524 384175
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Dear Lindy

Request for Ethical Clearance – Ref 12/14
Project: Comparing registered nurses perceptions and experiences of personal and professional development

Thank you for your application which has been given consideration by the Panel. The Panel are delighted to give approval for your project and wish you well.

We would also like to thank you for being thorough with the documentation provided The approval from Edinburgh University have been placed on file.

Yours sincerely

Dr Ian Convery
Chair
Ethics Advisory Panel

Appendix F **Recruitment Leaflet**

Perceptions And Experiences Of Registered Nurses Personal and Professional Development

Lindy Hatfield
University of Edinburgh
PhD Student
l.m.hatfield@sms.ed.ac.uk

What if I've got questions?

If you want to ask anything about the work please get in touch with

Lindy Hatfield
l.m.hatfield@sms.ed.ac.uk

What if I have concerns?

If you have concerns that you would like to discuss with someone independent of the study, please get in touch with

Professor Pam Smith

School of Health in Social Science, University of Edinburgh, Teviot Place, Edinburgh EH8 9AG

Pam.smith@ed.ac.uk

About Lindy

I am a registered nurse and I have worked in a variety of public and private healthcare organisations, before moving into University Education.

I work at the University of Cumbria, UK as a Senior Lecturer in Nursing.

I am studying a part time PhD at the University of Edinburgh, Scotland, UK.

I am visiting Cape Town from the 19th February until the 22nd March 2013. I would like to talk to registered nurses and hear about their perceptions and experiences of personal and professional development.

Taking part in the research

What will it involve?

The research will involve me arranging to meet with you, so that I can ask you a set number of questions based on your experiences and perceptions of personal and professional development (PPD).

Prior to the interview I will send you some forms to quickly fill in. I will ask you to complete a short answer questionnaire, and a consent form and ask you to bring them to the interview (I will have spare hard copies available, if you would rather fill them in at the interview).

All participants will remain anonymous within the research. You can withdraw at any time during the research.

What happens next?

I would be very grateful if you could email me to say if you are willing to volunteer, to meet with me for 1-1.30hrs
l.m.hatfield@sms.ed.ac.uk

From: Tuesday 19th February until Friday 22nd March 2013. I will reply; confirming with you, our agreed date, time and place to meet.

Ideally I would like to meet you in person, on a University site. However, we could arrange to meet in alternative public place.

Prior to the interview I will send to via your email address or by letter; more information about the research.

What will happen as a result of the work?

I will write a PhD thesis for the University of Edinburgh. I will also write some articles and research papers on my research experience. In the end I hope that the work that I do, will help raise awareness of registered nurses perceptions and experiences of personal and professional development in this current climate.

I hope to highlight some effective ways in which nurses are managing to undertake PPD. I will be discussing the difficulties that nurses may come across in their PPD. This research will also highlight differences between UK and SA nurses experiences and perceptions of PPD.

Appendix G **Participant Information Sheet (PIS)**

Participant Information Sheet

Title: Comparing Registered Nurses Perceptions and Experiences of Personal and Professional Development

You are invited to take part in this study which aims to explore Registered Nurses perceptions and experiences of personal and professional development.

What are the reasons for the study?

To find out how women are undertaking personal and professional development. What has helped or hindered them, and what are the commonalities and differences between the UK and SA nurses.

Why have I been asked to participate?

You have been invited to take part in this study because you are a registered nurse with more than 2 years post registration experience.

Who will be selected?

Women with two or more years post registration experience
.

Do I have to take part?

No. Taking part in a research project is completely voluntary. It is up to you to decide whether you wish to take part or not. You will be given this information sheet in order to decide whether you wish to take part and a copy of the consent form. If you decide to take part I will ask you to sign the consent form. There will be no financial incentives in taking part in this study.

Even if you do decide to take part, you can still withdraw from the study at any time without giving a reason and without any disadvantage to your work. In this instance I will not use any of the information you have given me.

What does the Research Involve?

Completing a Short Answer Questionnaire and attending an interview.

What are the benefits and risks to taking part in the Research?

I hope that by conducting this research I can address the future needs of Registered Nurses both in the UK and SA. Highlighting areas of good practice.

You may find being able to talk about your experiences very helpful as I will really aim to listen to what you have to tell me. I appreciate however that revisiting these experiences may be difficult for you and there will be the opportunity to refer you for additional support if you feel you would like this.

Will the research remain Confidential?

Yes. The study will be conducted in confidence and no names nor identifying data will ever be used when presenting any information. As the researcher, I will take care to anonymise situations and will seek your permission before using any examples from your experience in my research.

Your rights under the Data Protection Act 1998 remain at all times.

All information collected during the project will be kept securely and only myself, my supervisors and the transcriber will have access to it. Our procedures for handling, processing, storage and destruction of the data will comply with the Data Protection Act 1998.

What will happen at the end of the Study?

The study will take place from October 2012 to June 2013. Once the information has been collected it will be used within the PhD Dissertation and subsequent publications.

Who is organising and funding the study?

This study is being organised by Lindy Hatfield PhD student at the University of Edinburgh, currently it has no funding.

What if I have any concerns?

If you have any further questions or concerns regarding the study please contact:

Contacts for Further information:
My contact: lindy.hatfield@cumbria.ac.uk
Supervisors: s.rodgers@ed.ac.uk and pam.smith@ed.ac.uk

Appendix H **Data Demographic Sheet (DDS)**

Interview Date:

Comparing Registered Nurses Perceptions and Experiences of Personal and Professional Development – Lindy Hatfield

SHORT ANSWER QUESTIONNAIRE

The questions contained in this questionnaire are aimed to collect the demographics and professional status and experience of participants

Name: **Contact email/address:** To send you information on the research findings	**Age:** **Nationality :** ☐ S. African ☐ other ☐ British

Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Ethnic Origin:
SA terms
Re-2011 census ☐ white ☐ black African ☐ coloured ☐ Asian ☐ Indian ☐ other .....

UK terms ☐ White British ☐ white (other) ☐ Indian ☐ Pakistani ☐ mixed race ☐ Bangladeshi
Re-2001 census ☐ White Irish ☐ Chinese ☐ Asian (other)
☐ Black Caribbean ☐ Black African ☐ Black (other)

Disability: ☐ No ☐ Yes

Number of Children: 0 ☐ 1 ☐ 2 ☐ 3 or more ☐	What area do you live in: ☐ City ☐ Semi-Rural ☐ Rural Do you have access to the internet: ☐ at home (where you live) ☐ at your family home ☐ not at home Do you own your own computer? ☐ yes ☐ no Do you share a computer with someone else? ☐ yes ☐ no

PROFESSIONAL DETAILS

What nursing qualifications have you obtained?	☐ Registered Nurse Additional qualifications ☐ Midwife ☐ Other .....

1

What other qualifications do you hold: Please list any other additional qualifications you have gained	☐ Higher Cert in Auxiliary Nursing ☐ Enrolled Nurse ☐ Diploma ☐ Degree/bachelors ☐ Masters ☐ PhD ☐ certificate or modules of academic credit in specialist subject …… ……	
In your current role (or most recent) who were/are your employers:	☐ government run health service	☐ Voluntary or Charitable organisation
	☐ Private health care organisation (Hospital)	☐ Private health care organisation (Nursing Home)
	☐ private employer	☐ Other .e.g. in education and training, or consultant work, please list ……
How many years have you been qualified as a nurse? …… **What year did you gain your nursing qualification? ……** What is the highest position and/ or wage that you have earned? …… **What job role do you currently hold (or previously held)?** Is this in private or public (government run) organization? …… …… …… ……		
In your main job role (or most recent) do you work on a	☐ full time contract	☐ part time contract
	☐ full time bank/ agency	☐ part time bank/ agency
	☐ other …… …	other
Do you have more than one job, please state what other jobs you carry out? …… ……		
Please bring this form with you to the interview (or I have hard copies for you to fill in at the interview, thank you).		

Appendix I **Interview Guide**

Interview Questions

As a registered nurse what is your perception of Personal and Professional Development (PPD)?

Do you think that they are joined together or separate?

Within your work environment who has given you support with your PPD?

Outside of the work environment who has supported you with your PPD?

What actions, activities, techniques or strategies have you used to undertake professional development? Explored further in discussion if required

What actions, activities, techniques or strategies have you used to undertake personal development? Explored further in discussion, if required

What is your perception of the benefits and/or the rewards that you may be able to gain from undertaking PPD?

What benefits or rewards have you gained from having carried out PPD?

I would like to ask you what difficulties you may have encountered when trying to undertake PPD? Explored further in discussion, if required

Within the work environment? Outside of the work environment?

Do you think that your experiences are similar to other female nurses?

Is there anything else that you think that I should know, or be aware of with regards to personal and professional development that will be helpful in my research?

Towards the end of research I asked participants to if they knew of any RNs that took sick leave so that they could do their PPD.

Appendix J **Audit Trail original data to codes and categories**

1st set of interviews SA and UK

Analysis of data

Open Coding of data

1st Core category emerging, coding chart started to develop, constant comparison undertaken

2nd set of interviews UK, SA and UK theoretical sampling took place

Analysis and coding of data

1st core category confirmed through focused coding

Revisions and focused coding and analysis

2nd main category emerging

3rd main category emerging

4th main category emerging

Revisions of focus coding and analysis

Categories confirmed and renamed as themes